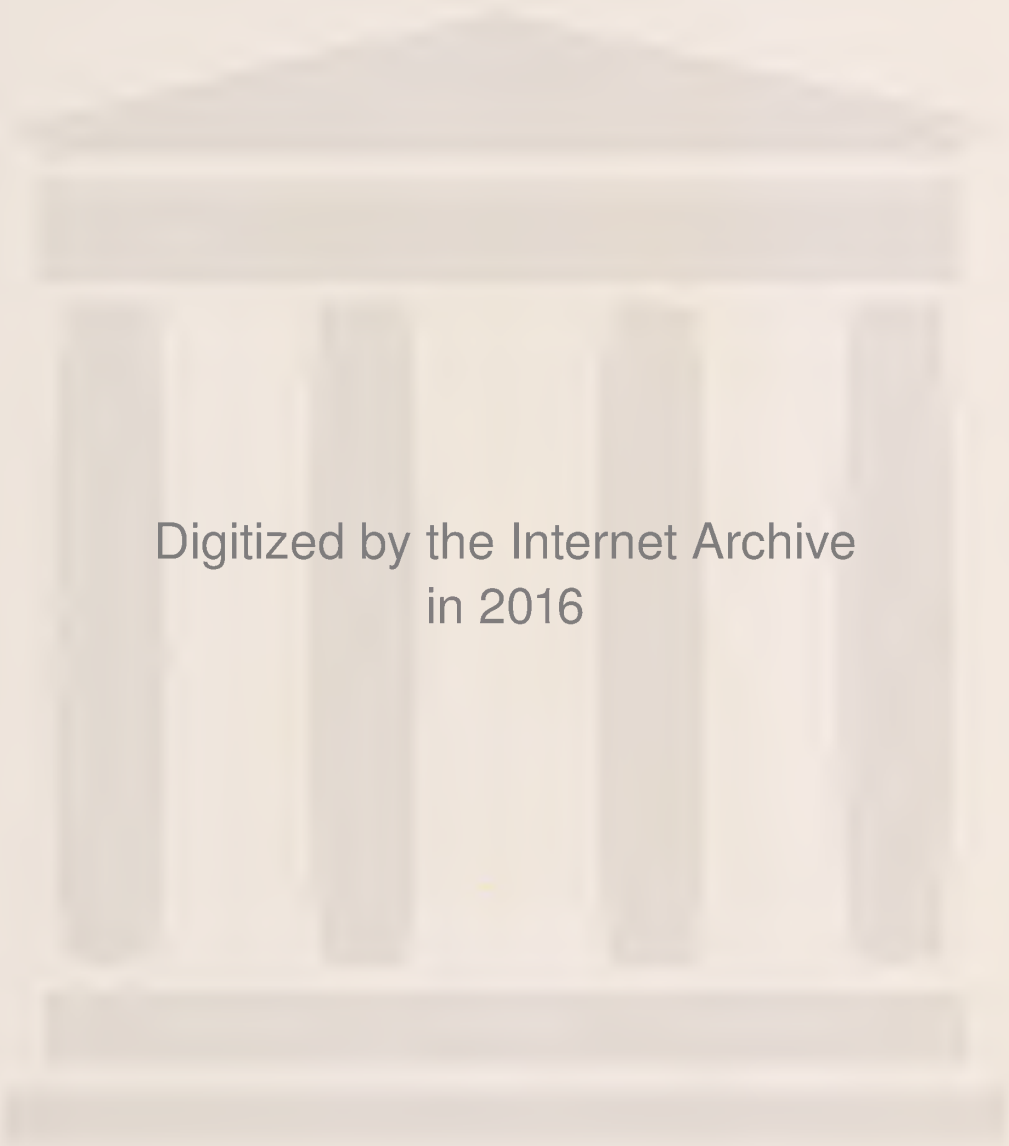
PER

The New York
Academy of Medicine



Library Fund
(General)

Established 1878



Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofflorida552unse

BALCONY

THE JOURNAL OF THE

Florida Medical ASSOCIATION

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M D

JULY, 1968 • VOLUME 55 • NUMBER 7



The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

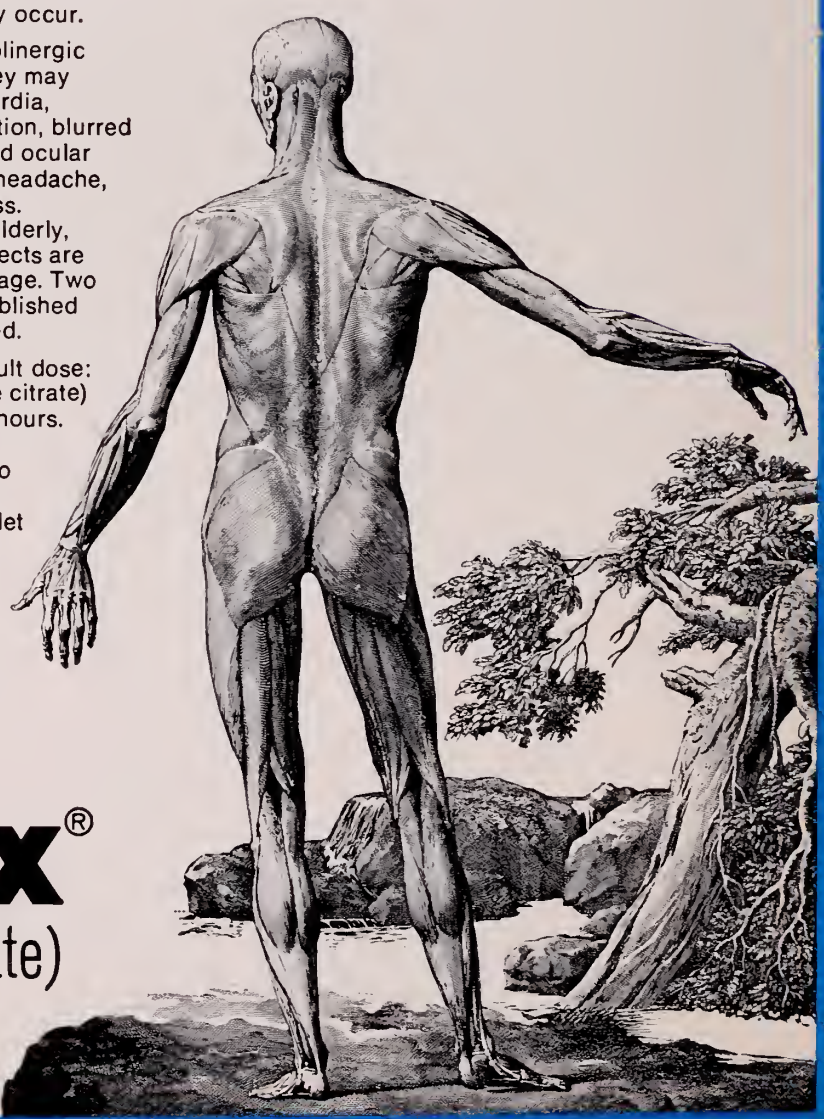
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



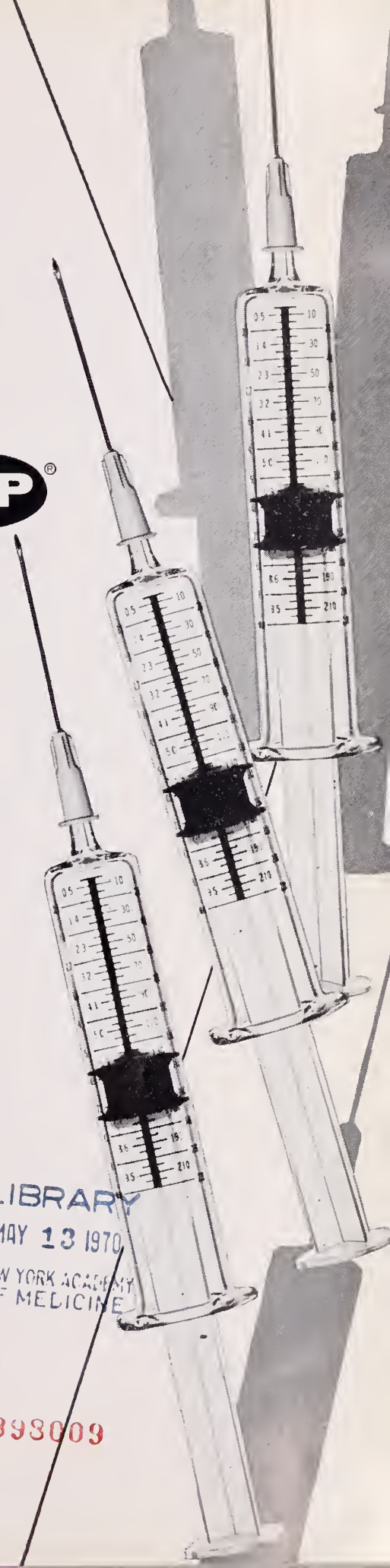
Norflex®
(orphenadrine citrate)

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



ROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

LIBRARY
MAY 13 1970
NEW YORK ACADEMY
OF MEDICINE

398009

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

THE JOURNAL OF THE
Florida Medical
ASSOCIATION
JULY, 1968 • VOLUME 55 • NUMBER 7

scientific

Drug Induced Photosensitivity 607
CHARLES M. DAVIS, M.D. AND VICTOR H. WITTEN, M.D.

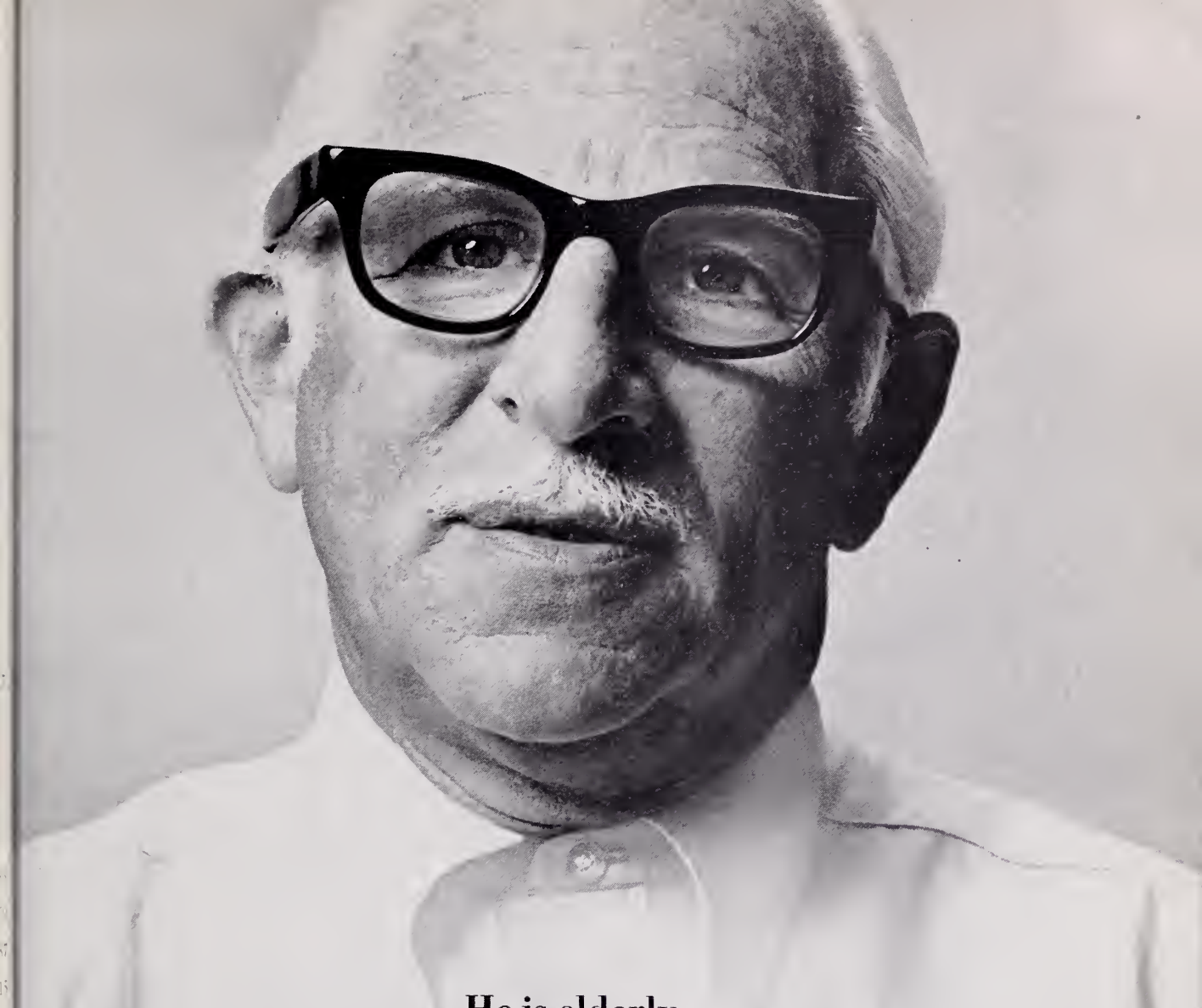
sections

Comment 683
Editorial 679
Feature 687
Organization 615
PROCEEDINGS OF THE 94TH ANNUAL MEETING
President's Page 597

information

Advertisers 703
Classified 699
County Medical Societies of Florida 694
Florida Medical Association Officers, Councils and Committees, 1968-1969 695
Index to Proceedings 702
Information for Authors 595

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

uard susceptible patients against intestinal monilial over-th during broad-spectrum therapy—the protection of atin is combined with demethylchlortetracycline in LOSTATIN.

r your susceptible candidates, prescribe DECLOSTATIN broad-spectrum therapy that prevents monilial growth.

aindication: History of hypersensitivity to demethylchlortetracy- or nystatin.

ing: In renal impairment, usual doses may lead to excessive accumu- and liver toxicity. Under such conditions, lower than usual doses dicated, and, if therapy is prolonged, serum level determinations e advisable. A photodynamic reaction to natural or artificial sun- has been observed. Small amounts of drug and short exposure may ce an exaggerated sunburn reaction which may range from ery- to severe skin manifestations. In a smaller proportion, photo- ic reactions have been reported. Patients should avoid direct ure to sunlight and discontinue drug at the first evidence of skin nfort. Necessary subsequent courses of treatment with tetracy- should be carefully observed.

utions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES, A Division of American Cyanamid Company
Pearl River, New York



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 4864

Announcing the blood chemistries anyone in your office can do.

Those using Diagnostest* reagents and instruments. We train your nurse or medical assistant to use this simple, accurate system. For measuring hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. You get results in minutes. And the system includes everything you need. Write today for full information.

*Trademark of The Dow Chemical Compa

DOW

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograpb *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number, 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P.O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE
Florida Medical
ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

OSCAR W. FREEMAN, M.D.
Assistant Editor

RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

GEORGE H. ROWE JR.
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor

JULY COVER

The figure cast in bronze by Dr. John W. Snow of Jacksonville won first prize for sculpture in the physicians' art show (see page 685). It was chosen as symbolic of the 1968 FMA Annual Meeting. William Elsner Jr. of Jacksonville was the photographer. For the June cover Everglades picture, the Journal is delighted to give deserved credit to the Florida Development Commission.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg. Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets, you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient. Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention.
Caution ambulatory patients that drowsiness may result.

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



"Nothing else I've tried seems to work, so I decided to give you a crack at it."



Thoughts on the 1968 Annual Meeting

First, I think we had a good meeting overall. The registration was the highest we have ever had in the history of the Association. There was a tremendous amount of interest shown in the proceedings of the House of Delegates, albeit some of the matters were quite controversial. I think that the Speaker and Vice Speaker did an outstanding job in keeping the meeting on an even keel.

The increasing amount of work necessary to be done by the House makes me wonder if perhaps we should change the format so that we can finish on Sunday by noon before everyone becomes worn out. The election of officers and delegates and the installation ceremony should not be a hurried affair. One suggestion has been made (not original with me) that we have half the second meeting on Saturday afternoon and the other half on Sunday morning. Most of the specialty meetings on Saturday are over by 3:00 or 3:30 and all the reference committee reports are ready by Saturday afternoon. In my opinion, we should make some change so that we do not run until two or three o'clock on Sunday afternoon. The hotel usually has a lobby full of new guests waiting for our rooms by two o'clock. This is purely a thought. If any of you have a really good suggestion as to how we can expedite the meeting next year, please let me or Mr. Parham know. We promise we will consider every idea you give us.

Speaking of Mr. Parham, I never before was aware of what a tremendous job he and his administrative staff have to do to keep every detail in mind and to keep our meeting running smoothly. I want to say publicly how much I personally appreciate all the things he and his staff do constantly for FMA.

Jack D. Cleveland

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

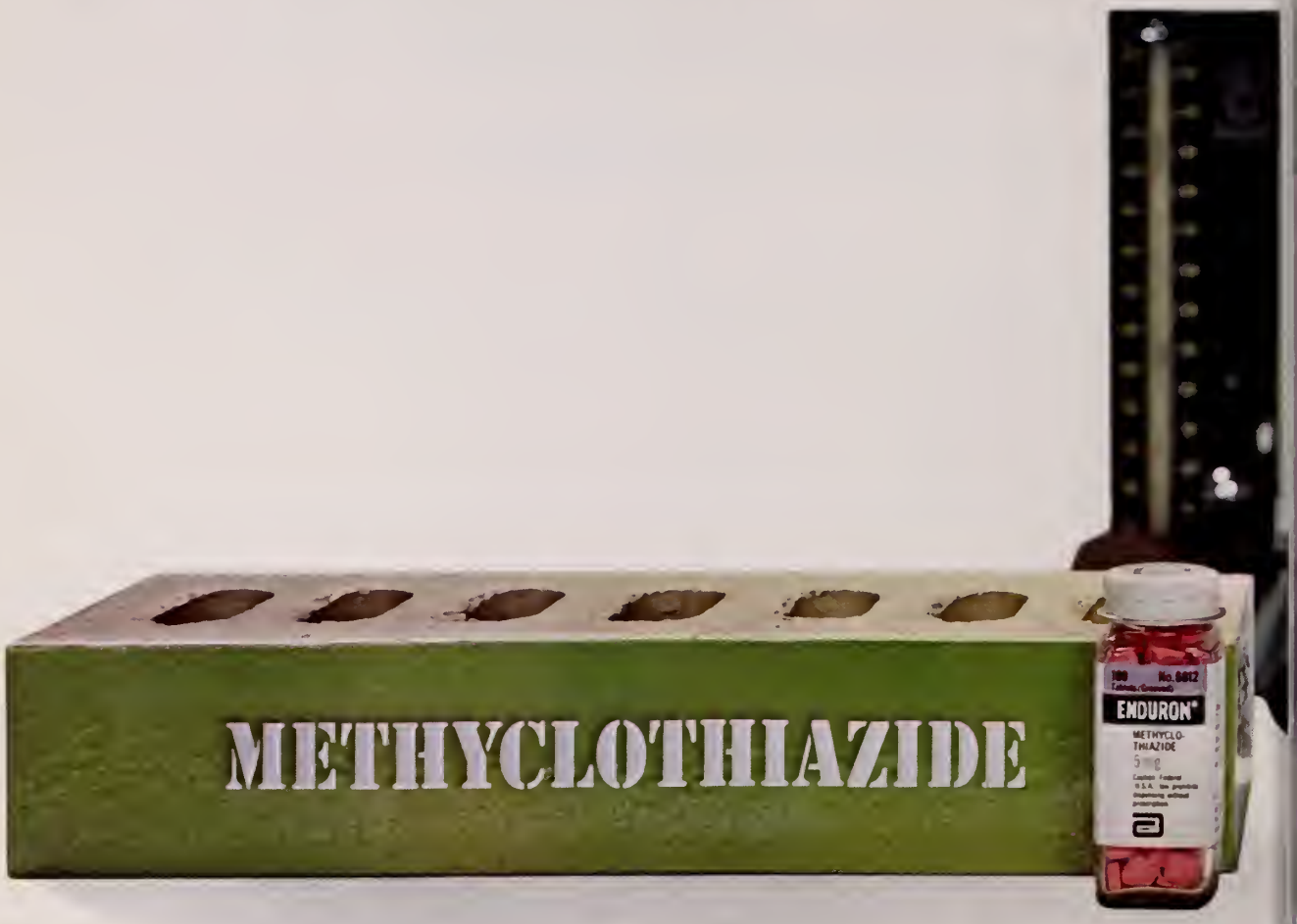
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

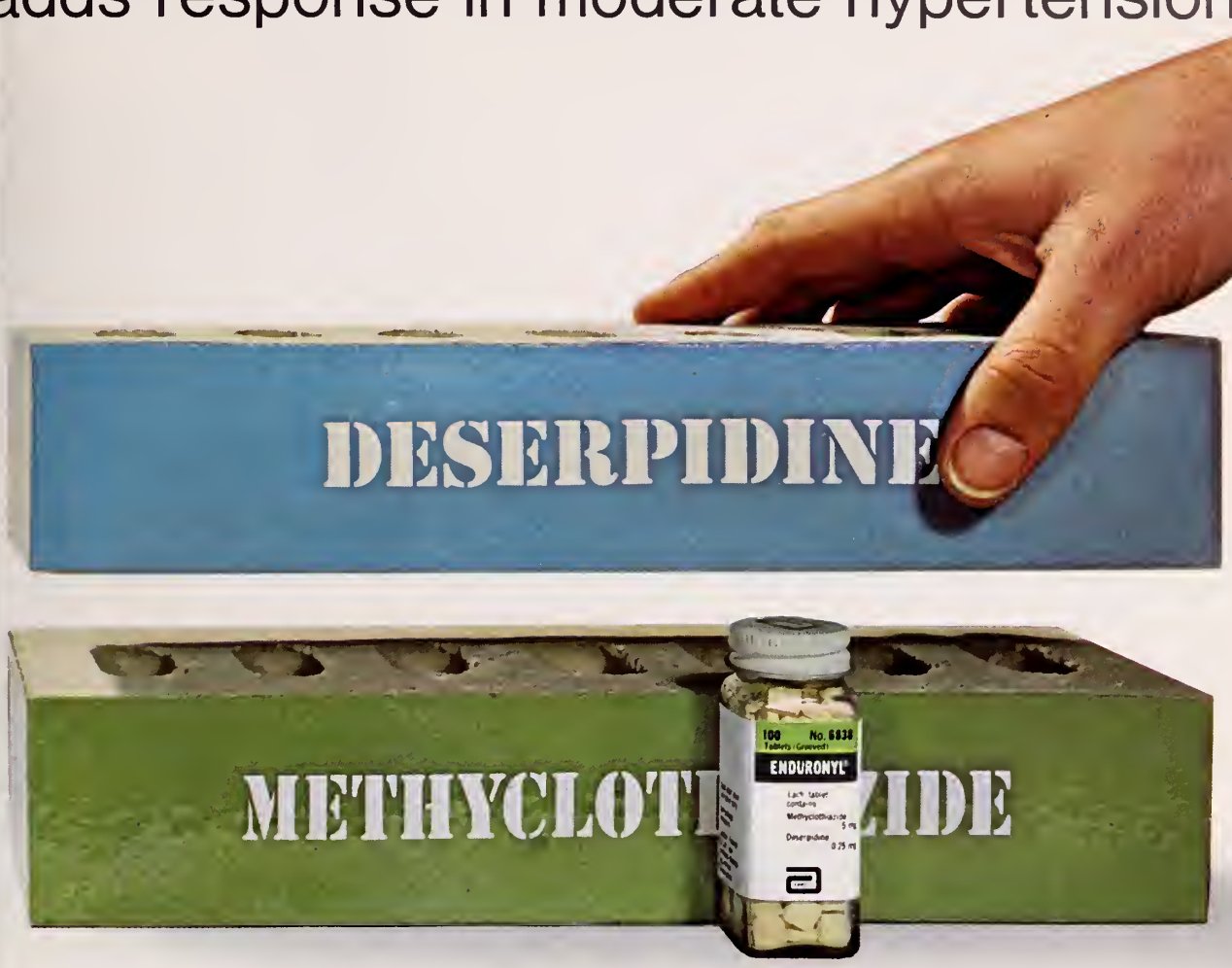
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

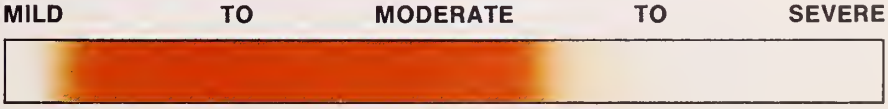
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

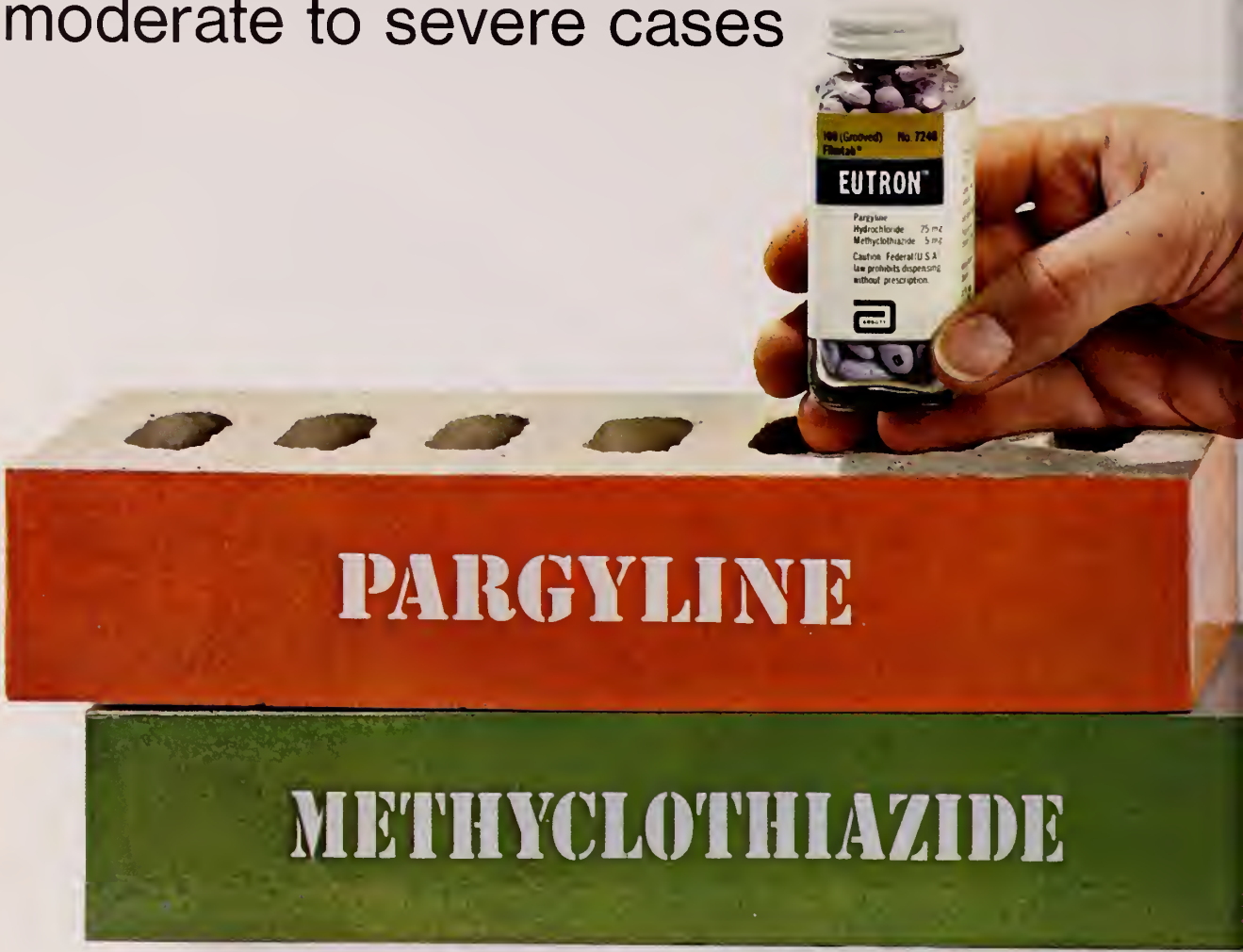
METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

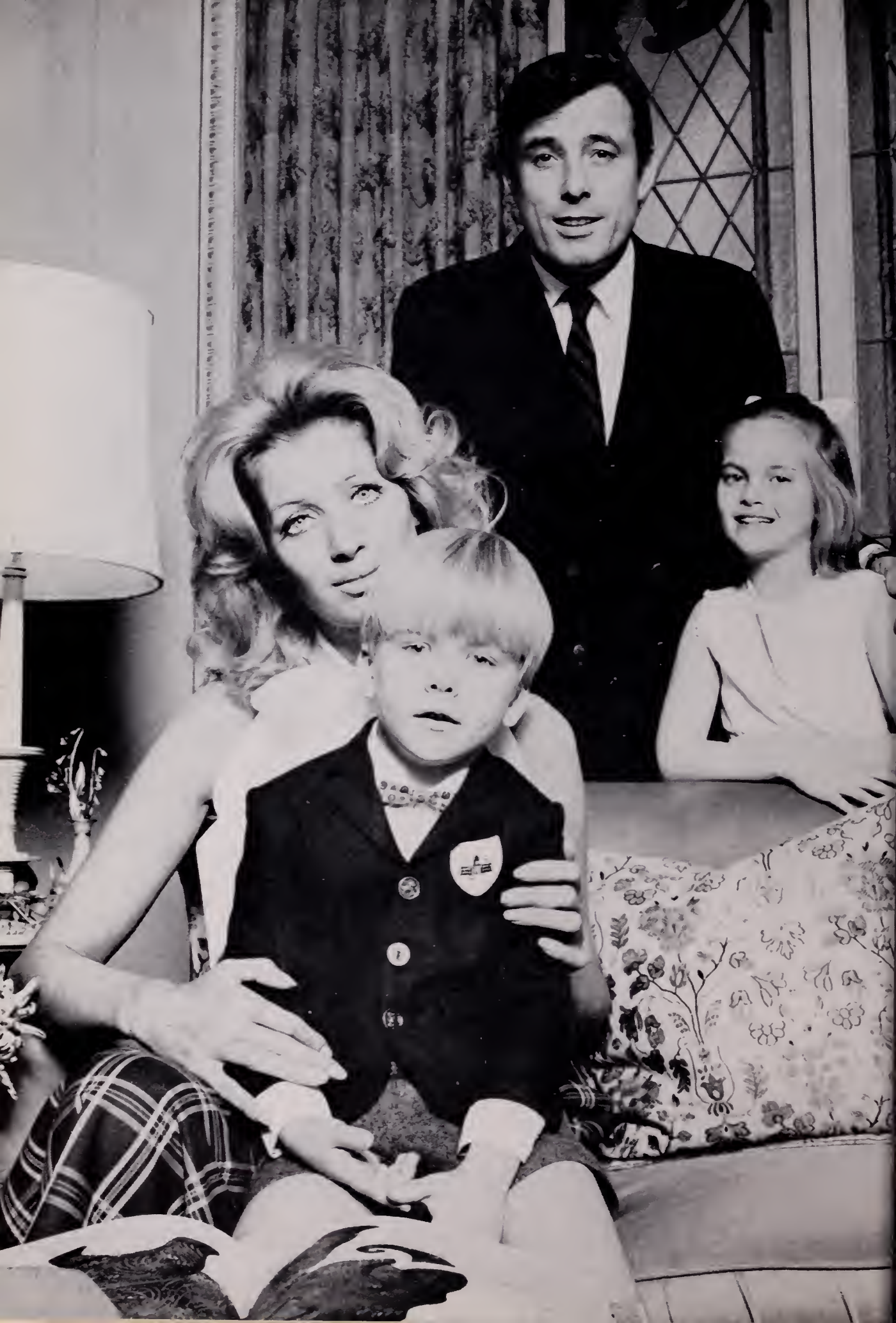
Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK



pinworms
n this
amily?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

...and if hygienic measures alone are not enough...?

when examination reveals pinworm infection, estimated to occur in from ⅓ to more than ½ of all American children from every social level, an increasing number of physicians favor treatment with a single, economical dose of—

Povan®
(pyrvinium pamoate)

PARKE DAVIS & COMPANY DETROIT MICHIGAN 48232

PARKE-DAVIS

33668

pressure
PRESSURE
Sixth Straight Setback
New York Stock Exchange Trading
Drop
DISTRICT COURT
NASSAU COUNTY
Internal Rev
310 Lowell Street
VIOLATIC
NO PARKING ZO
RESERVED SPACE
BLOCKING DRIVEW
EMERGENCY DRIVEW
WITHIN 10 FT. OF FIR
PARKING WITHOUT PE
PARKING IN UNASSIGN
PARKING IN LOADING DOCK
WARNING
7/29/6

When life's pressures build up blood pressure

in the hypertensive patient

s pressures and frustrations can often set stage for a rise in blood pressure in the rtensive patient. Emotional fluctuations of d pressure may be especially intensified in ard-driving, aggressive individual who inuously pushes himself. Along with your ce to help the patient adjust to living with rtension, you can also prescribe help in form of HYDROPRES.

ROPRES, a combination of two proven anti-rtensive agents, has a mild tranquilizing ct that lets the patient relax as it reduces lood pressure. It alleviates symptoms as-ated with hypertension, such as headache tachycardia, that frequently reflect the eral tenseness of the patient.

It's worth noting that potassium loss with HYDROPRES at usual therapeutic doses is usually minimal, and a diet rich in potassium normally avoids serious depletion.

Another point to remember: When other antihypertensive drugs are used adjunctively they must be given at one-half their usual dosage simply because HYDROPRES potentiates the action of such agents. HYDROPRES is contraindicated in anuria and in patients known to be sensitive to hydrochlorothiazide or reserpine.

So, when life's pressures build up blood pressure, consider HYDROPRES to help your hypertensive patient feel more relaxed while under pressure.

HYDROPRES®

ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES-50:
50 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

helps your patient relax as it lowers his blood pressure

For additional prescribing information, please see following page.

INDICATIONS: Mild to severe hypertension.

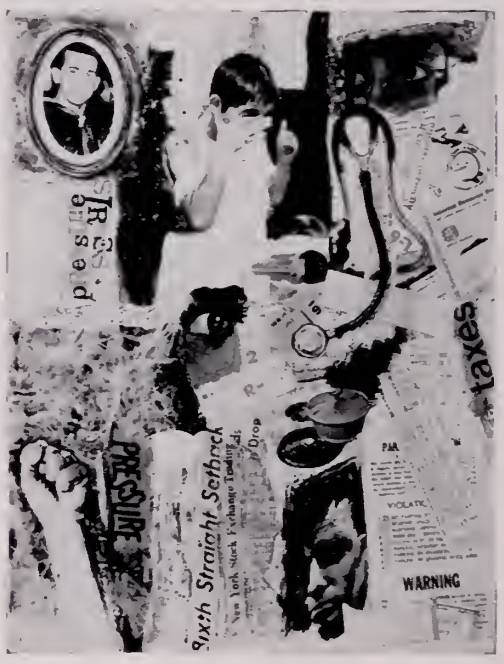
CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to hydrochlorothiazide or reserpine. Nursing mothers. Electroshock therapy; discontinue drug at least 7 days before initiating electroshock therapy.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis. Dosage of other antihypertensive drugs, especially ganglion blockers, must be reduced by at least 50 percent because HYDROPRES potentiates their action. A further reduction in dosage or even discontinuation of the other antihypertensive drugs may be necessary as blood pressure falls. Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery frequently required and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs. The possibility of sensitivity reactions should be considered in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives (including thiazides) and reserpine. Nasal congestion, lethargy, depressed Moro reflex, and bradycardia may appear in infants born of reserpine-treated mothers. Thiazides cross placenta and appear in cord blood. In women of child-bearing age, potential benefits must be weighed against possible hazards to fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS AND SIDE EFFECTS: **Hydrochlorothiazide:** Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive, or patient is receiving parenteral fluids or medication such as digitalis. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant steroid or ACTH therapy, or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypochloremic alkalosis occurs infrequently and is rarely severe. If dietary salt is unduly restricted, especially during hot weather, in severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. Insulin requirements in diabetics may be altered. May produce hyperglycemia and glycosuria in latent diabetics. Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, jaundice. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have associated thiazides with pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. Whenever adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn. **Reserpine:** Reactions most often reported include excessive sedation, nightmares, nasal congestion, conjunctival injection, enhanced susceptibility to colds, muscular aches, headache, dizziness, dyspnea, anorexia, nausea, increased intestinal motility, diarrhea, weight gain, dryness of mouth, blurred vision, flushing of skin, and pruritus. Skin rash, dysuria, syncope, nonpuerperal lactation, impotence or decreased libido, angina pectoris, other direct cardiac effects (e.g., premature ventricular contractions, fluid retention, congestive failure), and CNS (including occ sensitization have been noted. Use cautiously in hyperter patients with coexistent coronary artery disease to avoid cipitous drop in blood pressure. Since reserpine may incr gastric secretion and motility it should be used cautious patients with history of peptic ulcer, ulcerative colitis, or c gastrointestinal disorders. May precipitate biliary colic ir tients with gallstones, or bronchial asthma in suscep patients. May cause hypotension, including orthostatic h tension. Since significant hypotension and bradycardia develop during anesthesia, discontinue two weeks pric surgery. A Parkinson's disease-like syndrome, usually rev ible with decreased dosage or discontinuance of therapy, been observed. Anxiety, depression, or psychosis may dev Pre-existing depression may be aggravated.

Before prescribing or administering, read product circular package or available on request.

helps your patient relax as it lowers his blood pressure



HYDROPRES
ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRE
50 mg. hydrochlorothi
0.125 mg. reserpine per t

MERCK SHARP & DOHME | **where today's theory is tomorrow's thera**
Division of Merck & Co., Inc. West Point, Pa. 19486

Open-eyed nights





...too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. In relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects, particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

ROCHE

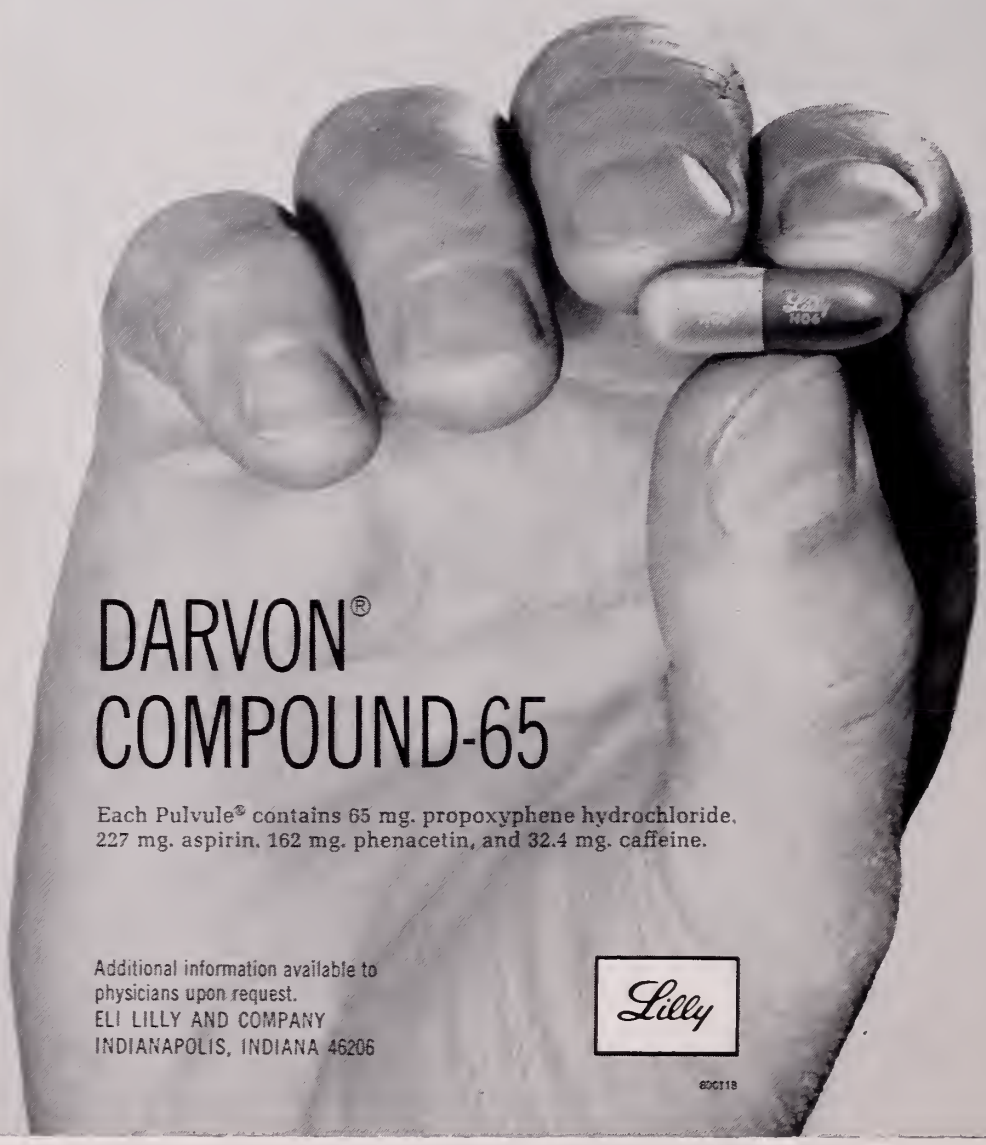
Roche® LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium®(diazepam)

useful for the relief of psychic tension, alone or with associated depressive symptoms

Part of
the fine art
of medicine



DARVON®
COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206

Lilly

69C118

Florida Medical | scientific

Drug Induced Photosensitivity

Charles M. Davis, M.D. and Victor H. Witten, M.D.

Photosensitivity reactions of the skin may result from certain drugs administered systemically or topically in combination with exposure to sunlight.[1-5] The dermatitis which results may appear in several forms, such as an exaggerated sunburn reaction (which frequently may be followed by pigmentation), urticaria, purpura, erythematous papules, with or without vesicles, or as an acute eczematous process. Of particular diagnostic value is the localization to skin which is exposed to light and the sparing of areas ordinarily not exposed, as under the chin, the upper eyelids and behind the ears. The sulfonamide drugs have long been recognized as a cause of photosensitivity; similarly, the sulfonamide derivatives, sulfonylurea hypoglycemics and thiazide diuretics cause similar problems. Demethylchlortetracycline and the phenothiazine derivatives may be potent photosensitizers.

Recently, certain of the antiseptics widely found in cosmetics, soaps, detergents, shampoos, first-aid creams and household cleansers have been shown to be a significant cause of the allergic type of photosensitivity. Bithionol, which is one of the most potent, has been eliminated from future use by the Food and Drug Administration, but it still may be found in existing supplies. Another group, the halogenated salicylanilides, are used in many products. They are present in "deodorant" toilet soaps such as Lifebuoy, Phase III, Praise, Safeguard and Zest and as antiseptics in various cleansers and laundry detergents. As these ingredients are frequently changed in today's competitive marketing practices, it is necessary to carefully check each label for the exact agents which have been incorporated. If no medical claims are made for the soaps, the offenders may be in the product but not mentioned on the label. Hexachlorophene and the carbanilides, which are commonly used for similar purposes, only rarely have been reported to cause photosensitivity.

Plants and oils which contain furocoumarins, in particular 8-methoxypsoralen, may sensitize the skin so that a sharply defined, intense sunburn reaction will follow sun exposure; the burned areas rapidly develop a marked pigmentation which may last for months or even years. This reaction is often referred to as berloque dermatitis. Common offenders are found in freshly cut limes and lemons, cologne waters and certain perfumes (in particular, Shalimar).

Lupus erythematosus, certain forms of porphyria and contact dermatitis due to airborne allergens may be confused with drug induced photosensitivity eruptions. In an effort to establish the diagnosis of drug induced photosensitivity, it is important to obtain a careful and detailed history.

Fortunately, a definitive diagnosis of photosensitivity due to topically applied agents can be

From the Department of Dermatology, University of Miami School of Medicine, Miami.

This study was supported in part by the Dermatology Foundation of Miami.

Dr. Davis currently is a captain in the U.S. Air Force Medical Corps. The views expressed herein are those of the authors and do not necessarily reflect the views of the Air University, the U.S. Air Force or the Department of Defense.



Fig. 1.—Acute dermatitis with purpura from chlorothiazide. Note sparing of skin under watchband on left wrist.



Fig. 2.—Acute papulovesicular eruption following demethylchlortetracycline.



Fig. 3.—Acute dermatitis of exposed parts following use of soap containing bithionol and bromosalicylanilide.



Fig. 4.—Acute dermatitis of hands and marked erythema of face and "V" of neck following use of soap containing bromosalicylanilide.



Fig. 5.—Typical distribution and configuration of erythema and pigmentation following application by fingers of perfume containing oil of bergamot.



Fig. 6.—Well defined erythema and edema with very early pigmentation; typical photosensitivity reaction from contact with cut limes.

Table 1—Common Photosensitizers*

ORAL

- Antimicrobials
  - Demethylchlortetracycline
  - Griseofulvin
  - Sulfonamides
- Diuretics
  - Chlorothiazide
  - Hydrochlorothiazide
- Hypoglycemic Agents
  - Chlorpropamide
  - Tolbutamide
- Phenothiazines
  - Chlorpromazine
  - Prochlorperazine
  - Promazine
  - Promethazine
  - Trifluoperazine

TOPICAL

- Antiseptics
  - Bithionol
  - Salicylanilides
- Plants or Derivatives
  - Limes
  - Oil of bergamot (perfumes)
- Preparations containing Coal Tar

*This partial listing contains the more common offenders.

made if appropriate photopatch tests are properly performed.[5]

The immediate management of the acutely affected patient obviously requires elimination of the offending agents, systemic or topical, and avoidance of sun exposure. Symptomatic therapy may include cool tap water soaks and the application of appropriate corticosteroid preparations. Patients more severely affected may require systemic corticosteroids. Occasionally patients manifesting photosensitivity to topical agents will continue to react to sunlight exposure for many months without known exposure to the offending agent or related chemicals. If sun exposure cannot be eliminated, then the patient is advised to wear a broad-brimmed hat and to adequately cover all exposed parts of the body. Sunscreen preparations, if they are opaque, may also be of some value. At present, Cashmere Bouquet, Ivory and Sweetheart soaps, among others, do not contain potentially photosensitizing compounds.

References

1. Sams, W. M.: Photosensitizing Therapeutic Agents, J.A.M.A. 174:2043-2048 (Dec. 17) 1960.
2. Hicks, J. H.: Demethylchlortetracycline: A Double-Blind Study in the Treatment of Acne with Attention to Side-Effects Noted. South. M. J. 55:357-360 (Apr.) 1962.
3. Schorr, W. F. and Monash, S.: Photo-Irradiation Studies of Two Tetracyclines, Arch. Derm. 87:440-444 (Oct.) 1963.
4. Baer, R. L. and Harber, L. C.: Photosensitivity Induced by Drugs, J.A.M.A. 192:147-148 (June 14) 1965.
5. Ison, A. E. and Tucker, J. B.: Photosensitive Dermatitis from Soaps, New England J. M. 278-81-84 (Jan. 11) 1968.

▶ Dr. Witten, 1150 N.W. 14th Street, Miami 33136.

Need a pocket watch?



See your jeweler!

Need another car?



Visit your auto dealer!

Need optical services?

GUILD ℞ OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Just as the jeweler is trained in his field, and the auto dealer is knowledgeable in his business, the Guild Optician is an expert in *his.*

We say "Call on an expert . . ." because your local Guild Optician *is* an expert in mechanical optics. You know he is equipped to handle your most critical cases, both in experience and in training. You know also, because he is a Guild Member, that his standards are high, and that you can depend on him to accurately translate your patient's prescription and to render such after service as your patient might need, for the life of that prescription.

Your local Guild Optician also is an expert at working with your patient in an understanding manner when it comes to the styling and fit of your patient's frame. His stocks reflect not only the most modern fashions, but also the conservative styles that have lasted over the years.

There are, of course, many other areas in which your Guild Optician may be highly skilled: sub-normal vision cases, aphakic cases, contact lenses.

When *you* need optical services, think *first* of your Guild Optician! *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS



"Everything looks fine,
but we should do something about that extra weight you're putting on."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

381-8



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

Florida Medical organization

PROCEEDINGS

Ninety-Fourth Annual Meeting, Florida Medical Association, Inc., Hollywood, Florida, May 9-12, 1968

President's Address

W. Dean Steward, M.D.

Your association has not been idle the past year and, in fact, some of its councils and committees have been extremely active. It is not my purpose at this time to fill your heads with facts and figures; these are all available in the Delegates' Handbook and, in addition, will appear in printed form in the Journal. Also, I might add that the Constitution and Bylaws require the President to make an address, not give a report, at the annual session.

Two years ago, in this same room, you initiated the steps that were to lead me to the highest honor this association can give. At the time the recipient was humble and somewhat concerned as to his ability to carry out the function of this high office. Last year the mantle of leadership was placed on my shoulders.

I trust that I have not failed you, but I must hasten to add that the credit for any success attained does not belong to me. My powers of expression are not such as to adequately thank those officers, council chairmen, committee chairmen and committee members who have made this a year of success and the office of President one of pleasure as well as honor. With rare exception, every man called upon to serve did so, and did so with excellence—that is the secret of the strength of the Florida Medical Association. To Mr. Harold Parham and his excellent staff also must go much credit. They form the connecting thread that links together the activities of the FMA year in and year out.

I would be remiss at this time if I did not express a word of thanks to my associate, Dr. Oscar W. Freeman. His generosity and cooperation have enabled me to attend the many functions and activities that the office requires. Also, I must thank and recognize my devoted partner of 29 years. She has put up with me in good mood or bad, and has been most understanding and helpful in more ways than I can mention. In fact, last year when I failed to introduce her following my inauguration, I received sympathy instead of criticism because she recognized my chagrin at the oversight. Again, let me present my wife, helpmate and auxiliary member, Martha. And speaking of auxiliaries, I believe that I must congratulate the Woman's Auxiliary to the FMA, which has had a very successful year under the most capable leadership of Mrs. Russell B. Carson of Fort Lauderdale.

Ever since the shadow of socialized medicine fell across the land in the late forties, physicians have been asking themselves, "What will the future of medicine be?" For almost two years now we have had a form of federalized medicine. Undoubtedly more is to come. We must continue our efforts through state and national organizations to try to shape the rules and regulations in such a fashion that medicine still can be practiced with pride and independence. But it is not primarily the political future of medicine that I wish to discuss. Instead, it is the form of medical practice that will exist. I well recognize that I am not a seer, and that I am treading dangerous ground in looking into the future, but I am deliberately doing this at the urging of a very good friend who thought that the future of medicine was still bright, and that this thought needed expression.

For many years now the demand for medical care has been increasing. This is in part due to the affluent society in which we live, and more recently to the addition of federal monies to pay for medical care for the elderly and, in some states, the medically indigent. Coupled with this has been increasing research, expansion of medical school teaching faculties and an increase of physicians in government and hospital employment. The result has actually been a slight decrease in the proportion of physicians engaged in private practice to meet the increased demands. With our rapidly growing population the situation will gradually grow worse until the medical schools expand enough to fill the gap many years hence. There are several approaches to the solution of the problems. These have to do with personnel, methods of practice and technology. Over the years we will probably see the problems solved by all the approaches and a gradual blending of the three methods.

It is obvious that the medical schools cannot be expanded fast enough in the immediate future to turn out the required number of physicians. Several schools have entered the field of training doctors' assistants, the arguments being that many tasks a physician performs can be carried out just as well by less skilled or less highly trained personnel. This is true, but this is treading shaky ground because we will need to be careful about licensing and supervision. If not extremely wary we may awaken in 15 to 20 years to find that we have a large group of irregular practitioners dispensing second-rate medical care as has been reported to occur in parts of Russia. To me it would seem more practical and much safer to take members of the health team who are already aware of medicine's ethics and responsibilities and give them a little additional training and use them for medical assistants. I am referring to some of our large group of skilled and dedicated nurses. Licensed practical nurses can be produced in two years, and along with hospital aides can be used to carry out many nursing duties that do not require a registered nurse. As midwives, nurse trainees could care for many of the normal deliveries, giving the doctor, particularly in rural areas, much relief. Medically trained nurse assistants could make routine house calls, follow up office visits, and so forth. Surgically trained nurse assistants could take care of minor injuries, some minor surgery, dressings and the like. This would be an added incentive for nurses to remain in health care fields as it would give them an opportunity for increased participation and income.

Increased utilization will be made of anesthetist assistants, physical therapists, inhalation therapists, psychologists, social workers, optometrists, orthopedic technicians and most likely others as yet unnamed. A total of some 150 paramedical and related health personnel are now listed. These will act to extend and supplement the physicians' time, skill and judgment. All actual prescribing should remain a function of the physician, and all care rightly should be under his supervision. This should be guaranteed through changes in the medical licensing laws which would place them at least under the supervision of the medical examining board, and would act as a protective measure for the health and wellbeing of the public.

The type of practice engaged in will also change to some extent. Over the past 20 years there has been a gradual decline in the number of men in general practice, and particularly in solo general practice. This trend shows no signs of reversing. Medical knowledge is expanding at such a rapid rate that it is difficult even for the specialist to stay abreast of the new developments in a limited field. This, along with isolation from medical centers, tends to aggravate the problem of the rural community. A partial solution to this will be through the formation of more groups in practice. These may be single specialty, but more ideally should be multispecialty groups, especially in rural areas, and should be privately or com-

munity financed. With the rapid communications and transportation available today, there would be no valid reason for such a group not to make available the best in medical care to the patients in any rural or urban area.

Daily or weekly seminars should be available via closed circuit television sponsored by the FMA and the three medical schools, and consulting panels should be available to the physician in remote areas via two-way hookups, so that the consultant could see the patient and review the laboratory and x-ray findings in a minimum period of time. A decision could then be made as to whether treatment should be continued locally, or if the patient should be transported to the nearest medical center. This probably would be accomplished by helicopter ambulance, rooftop to rooftop.

In urban areas in Florida there are many groups in practice now. Most of these are single specialty associations, or GP groups. A few multispecialty clinics are functioning. A type of clinic practice is in effect in urban areas. These consist of groups of specialists in large medical buildings, or in small buildings scattered around hospital centers. Such groups will continue to increase as medicine can be practiced more efficiently under such an arrangement. I can envision that such groups over a period of time will make increasing use of the paramedical group previously mentioned for outpatient care as well as inpatient care. These changes probably will not shorten the work day, but will allow physicians to have more time off each year. Also, a new specialist is emerging, the emergency room physician, who in many cases well may replace or supplement the general practitioner or family physician. This appears to be especially true in urban areas.

With the changing economy and rapid rise of costs, automation is coming to the fore. In the foreseeable future third party payees, whether government or private insurance, are going to balk at the high cost of medical care, particularly where the cost factor is due to inefficiency. One area that immediately comes to mind is in the field of clinical laboratory studies and electrocardiography. Eight or ten automated procedures can be carried out as cheaply as one procedure done by a technician. Mass screening and routine EKG interpretations can be done by computers. There is going to be a demand for centralization of laboratory functions. Now is the time for the private sector to fill this void. Otherwise, the hospitals, which are already set up for this type



Dr. W. Dean Steward delivers his President's Address to the House of Delegates.

of procedure, will dominate the outpatient care of patients as well as inpatient care.

Here might be a good place to point out that hospitals, and similar institutions, through control of hospital privileges, can control the future practice of medicine. It is imperative that the private sector of medicine be on guard and zealously protect the privilege of hospital appointments, even though the board of governors has the final say. This is another reason why the medical profession should be represented on such boards and why medical staffs should be cohesive groups who will speak out as a unit in protecting items affecting the practice of medicine.

Postgraduate courses will increase, and will become readily available to the physician in his office or at home through use of educational television with scramblers. In part this will be stimulated by the recently enacted heart, cancer and stroke legislation. It is hoped that organized medicine itself will further stimulate such because of increasing pressure and suggestions that physicians be reexamined at intervals to insure that they are keeping abreast of medical progress. This type of "home learning" will keep the physician up to date and lessen the need for such reexaminations.

The third change that we will see in practice is one involving the increasing use of computers. Techniques for this have presently been worked out to some extent. They can be used to take and record patient interviews, thus presenting the doctor with a summary of the history when he

first sees the patient. Secondly, they can be used to record physical examinations with almost instant print out and retrieval, thus saving more time. Lastly, they can be used to speed up the carrying out of routine orders, laboratory and x-ray procedures. An additional factor in the last technique is that orders can be written (via electric touch pencil and electronic screen) from any unit in the hospital, and that an instant check can be made on laboratory and x-ray reports and on the patient's condition. It is entirely possible, since these units will most likely be hooked up through computer centers outside the hospital serving one or more hospitals, that nearby clinics or groups of physicians can be tied in with the same computer system, thus saving untold man hours in record keeping and in the care of hospital patients. Such efficiency would in addition allow each doctor to see more patients per working hour and thus help combat physician shortage.

Finally, I would like to suggest that the bulk of medical practice in the future will continue to be carried out by dedicated physicians truly interested in bringing to their patients the best of their abilities in a scientific and compassionate manner and that the practice of medicine will continue to be a stimulating and rewarding way of life.

General Session

Abel Seymour Baldwin Memorial Lecture

The General Session of the Ninety-Fourth Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 10, 1968 in the Regency Room of the Diplomat Hotel, Hollywood, Florida, by President W. Dean Steward.

Dr. Steward made the awards for best scientific exhibits: Honorable Mention, "Coronary Artery Resection and the Coronary Blood Conduit," Banning G. Lary, M.D., Miami; third place, "Nasal Cartilage Homografts," Grover W. Austin, M.D., St. Petersburg; second place, "The Surgical Treatment of Facial Fractures," John W. Stone, M.D. and Troy H. Hutchinson II, M.D., Lakeland, and first place, the Aesculapius Award of Mead Johnson Laboratories in the amount of $200, was awarded to Franklin G. Norris, M.D., Orlando, for his exhibit "Saphenous Vein as Arterial Substitute."

Dr. Steward recognized Mr. Phil Kronen, sales manager for Mead Johnson Laboratories, and thanked him in the name of the Association for the Aesculapius Award donated by his company.



Dr. Franklin G. Norris accepts from President Steward the Mead Johnson Aesculapius Award.



Dr. Walter H. Judd presents the Abel S. Baldwin Memorial Lecture.

The President then introduced Dr. Walter H. Judd, former medical missionary, representative for 20 years from the Fifth District of Minnesota, and now a contributing editor of Readers' Digest and commentator on world events on 900 radio stations.

Dr. Judd spoke on "The Physician's Place in Public Affairs." His address is available on stereo tape for the use of the component county medical societies upon request, and is published in this issue of the Journal on page 687.

The assembly gave Dr. Judd a standing ovation.

Dr. Steward: "Dr. Judd, I think this standing ovation more adequately speaks our thanks than anything I can add, but we do appreciate your taking the time from your busy schedule to come and be with us and bring us this wonderful message."

Dr. Judd: "I would be moved by their standing up if I did not realize they have been sitting there such a long time."

Meeting was adjourned at 12:10 p.m.

First House of Delegates

The House of Delegates of the Florida Medical Association convened at 9:10 a.m. on Thursday, May 9, 1968 in the Regency Room of the Diplomat Hotel, Hollywood-by-the-Sea, Florida, with Dr. James T. Cook, Speaker of the House, presiding.

The invocation was pronounced by Dr. Leo M. Wachtel of Jacksonville.

The Speaker announced the membership of the Credentials Committee: Drs. William W. Thompson (chairman), Vann Parker, James J. DeVito and Joseph P. Hendrix.

The chairman of the Credentials Committee, Dr. Thompson, reported a quorum of 230 delegates present out of a possible 277, which represented a majority of the delegates and a majority of the component county medical societies, and moved that the delegates be seated.

Motion was seconded and carried.

Delegates

ALACHUA — Henry J. Babers Jr., Billy Brashear, J. Maxey Dell Jr., Walter E. Murphree, William C. Ruffin Jr., I. Irving Weintraub.

BAY — Tim M. Smith, Malcolm M. Traxler.

BREVARD — Jack T. Bechtel, Daniel L. Donovan, Theodore J. Kaminski, Laudie E. McHenry Jr., Joseph C. Von Thron (Absent—Lee Rogers Jr.).

BROWARD — Miles J. Bielek, Russell B. Carson, Gordon B. Carver, Yale Citrin, Theodore W. Hahn, David C. Lane, J. Gordon McAllister, Nat T. McGehee Jr., Ray E. Murphy Jr., Henry D. Perry Jr., Lees M. Schadel Jr., Daniel C. Smith, Robert J. Steinborg, W. Dotson Wells (Absent—Leonard A. Erdman, David J. Lehman Jr., John H. Mickley, Diran M. Seropian).

CHARLOTTE — (Absent—Carl N. Reilly).

CLAY — William A. Mulford.

COLLIER — William J. Bailey, Fred A. Butler.

COLUMBIA — Frank E. Adel.

DADE — James L. Anderson, William G. Aten, Thomas J. Baker, Harvey E. Brown Jr., John G. Chesney, Richard C. Clay, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Richard C. Dever, Robert F. Dickey, Donald M. Dooley, Franklin J. Evans, Richard M. Fleming, M. Eugene Flipse, Thomas O. Gentsch, Maurice M. Greenfield, Marshall F. Hall, Henry C. Hardin Jr., Caroline B. Hunter, E. Douglas Hutson, Walter C. Jones III, James R. Jude, Banning G. Lary, Edward J. Lauth, John B. Liebler, Richard E. Litt, Donald F. Marion, Leon H. Mims Jr., Edwin P. Preston, James C. Pringle Jr., M. Murray Schechter, Daniel L. Seckinger II, Everett Shocket, Chauncey M. Stone Jr., William M. Straight, Charles F. Tate Jr., Arthur W. Wood Jr., Scheffel H. Wright, Nelson Zivitz (Absent—William A. Abelove, David J. Becker, Morris H. Blau, Manuel L. Carbonell, Lynn P. Carmichael, Chester Cassel, John E. Cunio, Joseph H. Davis, Victor D. Dembrow, Paul S. Jarrett, Albert C. Jaslow, Beverly B. Jones, David Kirsh, Samuel W. Page Jr., Edward W. St. Mary, Thomas W. Skaggs, Donald W. Smith).

DESOTO-HARDEE-GLADES — (Absent — Calvin W. Martin).

DUVAL — James L. Borland Jr., Clyde M. Collins, Ensor R. Dunsford Jr., Thomas S. Edwards, John J. Fisher, O. E. Harrell, Charles B. McIntosh, Thad Moseley, Harry W. Reinstine Jr., Wade S. Rizk, Wilbur C. Sumner, J. Champneys Taylor, William A. Van Nortwick, James W. Walker Sr., Jonathan H. Wood (Absent—Joseph K. David Jr., Gordon H. Ira Jr., A. Mackenzie Manson).

ESCAMBIA — William M. Colmer Jr., Frank B. Hodnette, William T. Patton, Lockland V. Tyler Jr., William M. C. Wilhoit (Absent—Reed Bell).

FRANKLIN-GULF—Joseph P. Hendrix.

GADSDEN-LIBERTY — James B. O'Connor.

HIGHLANDS — Donald C. Hartwell.

HILLSBOROUGH — Collin F. Baker Jr., Ernest B. Bourkard, Leffie M. Carlton Jr., Francis C. Coleman, Richard G. Connar, John C. Fletcher, Linus W. Hewit, James M. Ingram, Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, William W. Trice, James A. Winslow Jr., Henry L. Wright Jr.

INDIAN RIVER — E. B. Hardee Sr., James C. Robertson.

JACKSON-CALHOUN — William F. Brunner.

LAKE — J. Basil Hall (Absent—Frederick C. Andrews).

LEE-HENDRY — Wallace M. Graves Jr., H. Quillian Jones Sr., Edward W. Salko.

LEON-WAKULLA-JEFFERSON — Edward G. Haskell Jr., Nelson H. Kraeft, Alfred L. Lewis Jr. (Absent—Thomas G. Bouland Jr.).

MANATEE — Warren G. Darty, Roger A. Meyer, Joseph F. P. Newhall Jr.

MARION — West Bitzer, Henry L. Harrell.

MONROE — (Absent—Joseph J. Scarlet).

NASSAU — (Absent—Cecil B. Brewton).

OKALOOSA — William W. Thompson (Absent—Andrew F. Giesen).

ORANGE — Axel W. Anderson III, Louis P. Brady, Jesse W. Castleberry, Francis M. Coy, Robert W. Curry, Truett M. Frazier, Paul C. Harding, David Y. Hicks Jr., Harold W. Johnston, Louis C. Murray, Franklin G. Norris, Charles R. Sias, Edward W. Stoner, Miles W. Thomley.

PALM BEACH — Carl E. Andrews, Vernon B. Astler, James F. Cooney, Maxmilian A. Crispin, Gabino S. Cuevas, Russell D. D. Hoover, Bernard Kimmel, Bernard F. O'Hara, Nicholas S. Petkas, William H. Proctor, Myrl Spivey, Harold A. Yount.

PASCO-HERNANDO-CITRUS — William H. Hubbard, W. Randall Jenkins.

PINELLAS — William J. Dean, Joseph A. Ezzo, James C. Fleming, David S. Hubbell, Charles A. Johnson Jr., John T. Karaphillis, William H. Keeler III, Charles H. Lasley, Jack A. MaCris, Donald G. Nikolaus, Thomas M. Quehl, John N. Sourbeer, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood.

POLK — Edward C. Burns Jr., Howard M. DuBose, Spencer Garrett, John W. Glotfelty, Wiley E. Koon, Willard E. Manry Jr., James T. Shelden, Frank Zeller Jr.

PUTNAM — (Absent—Roy E. Campbell).
ST. JOHNS — James J. DeVito.
ST. LUCIE-OKEECHOBEE-MARTIN — John M. Gunsolus, Howard C. McDermid.
SANTA ROSA — (Absent—John P. Merchant Jr.).
SARASOTA — Samuel E. Kaplan, Henry G. Morton, Karl R. Rolls, Millard B. White (Absent—John M. Butcher).
SEMINOLE — John M. Morgan, Vann Parker.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Frederick T. Mickler Jr.).
TAYLOR — James A. Rawls Jr.
VOLUSIA—Michael R. Blais, William E. Carter, Thomas D. Cook, Thurman Gillespy Jr., Charles L. Rickerd.
WALTON — (Absent—McKinley Cheshire Jr.).
COUNCIL ON SPECIALTY MEDICINE — James D. Beeson, Jack H. Bowen, Andre S. Capi, James W. Clower Jr., Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Joseph G. Matthews, Sanford A. Mullen, Curtis G. Rorebeck, Walter W. Sackett Jr., Edward J. Sullivan Jr. (Absent—J. Alfred Bowers, Samuel G. Hibbs, Bernard L. N. Morgan).
DELEGATES TO AMA — Jere W. Annis, Reuben B. Chrisman Jr., Burns A. Dobbins Jr., Francis T. Holland, Robert E. Zellner.
PAST PRESIDENT AMA — (Absent — Edward R. Annis).
OFFICERS — Jack Q. Cleveland, James T. Cook, Charles K. Donegan, Irving E. Hall Jr., Floyd K. Hurt, George S. Palmer, W. Dean Steward.
BOARD OF PAST PRESIDENTS — Jere W. Annis, Samuel M. Day, H. Phillip Hampton, Ralph W. Jack, Walter C. Jones, Duncan T. McEwan, John D. Milton, George S. Palmer, Warren W. Quillian, William C. Roberts, Joseph S. Stewart, William C. Thomas Sr., Leo M. Wachtel, Robert E. Zellner (Absent—Orion O. Feaster, Frederick K. Herpel, Edward Jelks, Francis H. Langley, Robert B. McIver, Walter C. Payne Sr., Eugene G. Peek Sr., William M. Rowlett).

Motion was carried to adopt the order of business as printed in the Handbook.

The Speaker called attention to an error in the minutes of the last annual meeting: on page 665 of the July 1967 Journal, Resolution 67-16 was shown as not approved, whereas it should have been shown as approved and referred to the Board of Governors.

Motion was carried to approve the minutes as published in the July 1967 Journal with this correction.

The Speaker introduced the officers of the Association: Drs. W. Dean Steward, President; George S. Palmer, Immediate Past President; Jack Q. Cleveland, President-Elect; Irving E. Hall Jr., Vice President; Charles K. Donegan, Vice Speaker of the House; Floyd K. Hurt, Secretary-Treasurer, and Mr. W. Harold Parham, Executive Director.

The Speaker then instructed the House:

Remarks of the Speaker

This House of Delegates transacts its business according to a blend of rules imposed by its By-Laws, established by tradition, decreed by the presiding officer and generally pursuant to the dictates of General Roberts in his "Rules of Order."



Dr. William W. Thompson, chairman of the Credentials Committee, reports to the First House.

Our meetings are not rigidly codified, and the Speaker recognizes that the only reason for his existence is to enable this House to arrive at a majority opinion concerning what it wants to do and how to do it. Ever mindful that our rulings are subject to challenge and reversal by this House, our sole aim shall be to expedite the completion of your duties.

These remarks were referred to Reference Committee No. 3 and were approved as part of its report.

Three distinguished guests were introduced: Mrs. Russell B. Carson, President, and Mrs. Linus W. Hewit, President-Elect of the Woman's Auxiliary to the Florida Medical Association, and Mrs. Glenn T. Scott, Director, Woman's Auxiliary to the American Medical Association, Ponchatoula, Louisiana.

Mrs. Carson spoke briefly offering the services of the Woman's Auxiliary with its 26 county components in 33 counties, comprising over 3,000 members, to assist the Florida Medical Association in its programs. The Auxiliary, she stated, recognized the health career manpower shortage as the number one health problem of the nation and had 169 organized paramedical clubs in high schools with some 3,500 students enrolled indicating an interest in some health career. The Auxiliary is also awarding more than $15,000 in scholarships and loans to students in various health fields. She requested the assistance of the Florida Medical Association in establishing a Health Careers Council.

Mrs. Hewit also asked that the Auxiliary be advised what they can do to help the Florida Medical Association during the coming year.

Mrs. Scott brought greetings from the Woman's Auxiliary to the American Medical Association.

President Steward introduced Dr. Dwight L. Wilbur, president-elect of the American Medical Association, and Mrs. Wilbur.

The House gave Dr. Wilbur a standing ovation, both at the beginning and end of his talk.

Dr. Wilbur reviewed the striking changes in medicine in the past 25 years and warned of the inevitable changes in the future with increased knowledge in the science of medicine, changes in the organization of medical care, increased health insurance, government financing of health care, group practice and specialization and the ever-increasing demand for health care with much greater use of hospital facilities. The greatest problem facing organized medicine today, he said, was the need to plan for the future, to cooperate with government and to take the lead so that this lead will not go by default to others.

Dr. Wilbur reported that the Board of Trustees of the AMA has established a Committee on Planning and Development and urged every state and county medical society to establish a similar committee of its most intelligent, effective and experienced members to plan basically for the ideal that every American have the highest quality of medical and health care.

Dr. Donegan, Vice Speaker, took the Chair and introduced The Honorable Marshall M. Criser, president-elect of The Florida Bar.

Mr. Criser brought greetings from the 10,400 members of The Florida Bar. He spoke of the significance of the recently instituted and celebrated "Law Day," May 1, 1968, and the necessity for the restoration of law and order as the rule of our land. He spoke of the "barbarity of war in civil life" as evidenced by our daily newspapers pointing out that it is the responsibility of citizens to obey the law and to change the law when necessary, but the law cannot be changed in the streets. He called attention to the right to speak against anything we do not like in our country, but also that there is no right to violate the law of the land. He went on to say, "Mobs do not generate human progress—they retard it; mobs do not establish rights—they trample them; we know that mobs do not inspire the advancement of civilization—they retard it." He concluded by saying, "Let 1968 be remembered by history as the year we turned from the brink of the lawless jungle and returned to the pinnacle of the greatest free society devised by man. I encourage you as leaders of your profession—more importantly as leaders of your communities and your state—to be among those who stand up and let your fellow citizens know that disrespect and disregard for law and order cannot be tolerated in our society; that no matter how well motivated people may be, we have reached a time of potential explosion in our nation; that we are going to have to take a realistic approach to the problems of the day, and that through a return to law and order, a return to the Constitutional system, lies the only vehicle under which this great nation can continue to prosper."

The Speaker introduced Dr. Ernest B. Howard, assistant executive vice president of the American Medical Association, and Mr. Whalen Strobhar of the AMA Field Service Division.

Dr. Steward took the Chair and asked Drs. William E. Carter, Peter A. Drohomer and Michael R. Blais to escort Dr. A. M. McCarthy to the rostrum. He then presented to Dr. McCarthy the A. H. Robins Company "Annual Award for Outstanding Community Service by a Physician."



Dr. A. M. McCarthy of Daytona Beach receives the A. H. Robins Community Service Award from President Steward.

A. H. Robins Company Award

"For Outstanding Community Service by a Physician"

Alphonsus M. McCarthy, M.D., of Daytona Beach is the recipient of the 1968 Community Service Award of the A. H. Robins Company. Annually this signal honor is accorded a member of the Florida Medical Association who has rendered distinguished service in civic and community activities. The Association's Board of Governors makes the choice from candidates nominated by the component medical societies.

Dr. McCarthy was born in Grand Rapids, Michigan on March 27, 1899. He received his premedical training at Grand Rapids Junior College and in 1925 received a Doctor of Medicine degree from the University of Tennessee College of Medicine. While in medical school, Dr. McCarthy was elected to AOA medical honorary scholastic fraternity. In order to pay his way through medical school, he externed at St. Joseph's Hospital and worked as a barber, a trade he had learned to pay his way through high school and junior college.

Dr. McCarthy served an internship and a three year residency, including one year of pathology, at the Memphis General Hospital, now the John Gaston Memorial Hospital, and served an additional year's residency in pathology at the Methodist Hospital, Memphis, Tennessee. After completing his formal medical education, Dr. McCarthy was chief surgeon and medical director of the George C. Hickson Memorial Hospital, Electric Mills, Mississippi, from 1930 to 1940. During this period he served as president of both the Mississippi State Hospital Association and the Southeastern Hospital Conference.

In 1940 Dr. McCarthy was called to active duty in the U. S. Army Medical Corps; served as chief of surgery at Fort Benning, Georgia, and as chief of surgery and commanding officer of the 62nd General Hospital, European Theatre of Operations; received from the French government the Croix de Guerre with Star of Vermeil for his distinguished service, and was discharged in 1946 with the rank of colonel.

During his years of practice, Dr. McCarthy has been active in community and medical life and has made tremendous contributions in all aspects of both civic and medical life in Daytona Beach and Volusia County. Dr. McCarthy has served his county medical society as president from 1958 to 1959 and has served as a member of its executive, interprofessional, nominating and grievance committees and as a delegate to the Florida Medical Association Annual Meeting.

Always interested in the welfare of the community in which he lives, Dr. McCarthy has served on the board of governors of the Daytona Beach Chamber of Commerce, board of directors of the Volusia Chapter of the American Red Cross, board of directors of the Community Chest, board of directors of the Florida Division of the American Cancer Society, as president of the Daytona Beach Rotary Club and as president of the general staff and chief of surgery at Halifax General Hospital, Daytona Beach.

The dedication of this man is untiring and has accomplishments legion. In June of 1964 Dr. McCarthy was asked by the Halifax District Hospital board of commissioners to assume temporarily the duties of hospital administrator in order to improve the relationship between the professional staff and administration and to solve the hospital's fiscal problems. This he did in the short time of nine months, admirably handling a chaotic situation and restoring the confidence of the professional staff and the general public of the area in this highly respected institution.

The House gave Dr. McCarthy a standing ovation.

Dr. McCarthy thanked his friends in the county medical society who nominated him for this award, and also those in the state association who were responsible for it.

The President then asked Dr. William J. Dean to escort Mr. Harry T. Gray, the Association's legal counsel, to the rostrum and presented to him the following resolution:

Resolution

Whereas, Harry Taylor Gray, Esquire, of Jacksonville, Florida, a practitioner of law, has rendered distinguished and selfless service to the Florida Medical Association as its legal counsel since 1925; and,

Whereas, This friend of the medical profession was born in St. Johns, Kansas, December 7, 1890; attended Kansas High School; earned a bachelors degree from the University of Kansas; achieved the degree LL.B. at the University of Kansas School of Law; and,

Whereas, This eminent attorney began the practice of law in Jacksonville, Florida, in 1922 and remains in active practice as a senior partner in the firm of Marks, Gray, Yates, Conroy & Gibbs, during which time he has distinguished himself as a member and past president of the Jacksonville Bar Association (1935); member and past president of the American Association of Insurance Attorneys (1960); a fellow of the American College of Trial Lawyers; a member of the Florida Bar and the American Bar Association, the International Association of Insurance Counsel; and,

Whereas, This accomplished attorney has for forty-two years served with great expertise the Florida Medical Association, its component county medical societies, specialty groups and affiliated organizations, and generally extended such service with little or no financial compensation; therefore be it

RESOLVED, That a Certificate of Grateful Recognition be presented to Harry T. Gray as a small token of the warm appreciation that the officers, members and executive staff of the Association hold for the many years of outstanding legal services rendered by this grand gentleman and scholar.

Mr. Gray thanked the Association for this honor.



A Certificate of Grateful Recognition is presented to Mr. Harry T. Gray, FMA legal counsel.

Dr. Steward then announced that the Board of Governors had voted to present the following resolution to the four physicians who served in the 1967 Florida Legislature:

Resolution

Whereas, since 1947 no doctor of medicine has served as a member of the Legislature of the State of Florida, and

Whereas, the following four members of the Florida Medical Association were elected to and did serve in the 1967 Legislature; namely, Senators John J. Fisher, M.D. (R), Jacksonville, and David C. Lane, M.D. (R), Fort Lauderdale; and Representatives Richard S. Hodes, M.D. (D), Tampa, and Walter W. Sackett Jr., M.D. (D), Miami, and

Whereas, these physicians, while serving as elected officials, were extremely active and effective in fulfilling their legislative duties, both for their constituents and for organized medicine, and, in addition, voluntarily contributed their professional services in manning the Capitol medical dispensary established through efforts of the membership of the Florida Medical Association; Now, therefore, be it

RESOLVED, That the Board of Governors and the House of Delegates of the FMA recognize and commend the dedication to legislative duties and service on behalf of all Florida citizens performed by these physician legislators; and be it further



Florida's physician-legislators receive a resolution of commendation. Pictured (from left) are President Steward with Drs. Fisher, Lane and Sackett.

RESOLVED, That the physician legislators and their associates be encouraged in every manner possible to continue their dedication to public service in furthering the promotion of health care legislation, and legislation of interest to the general health and welfare of the citizens of this state.

Presented this 9th day of May, 1968, to ————— ————, M.D., at the First Session of the House of Delegates, Florida Medical Association Meeting, Diplomat Hotel, Hollywood, Florida.

A framed copy of the resolution was presented to physician legislators Drs. John J. Fisher, David C. Lane and Walter W. Sackett Jr. Dr. Richard S. Hodes was not present.

Dr. Steward then introduced his wife, Martha, his daughter, Frances, and her husband, Mr. John Bryan. He also recognized Dr. Meredith Mallory, past delegate to the AMA and Dr. Steward's associate for 21 years.

The President then gave his annual address.

(The complete text of President Steward's address begins on page 615)

At the end of his address, the House gave Dr. Steward a standing ovation.

Dr. Donegan took the Chair and called attention to a change in Reference Committee personnel as printed in the Handbook: Dr. William C. Roberts will serve as Chairman of Reference Committee No. III, instead of Dr. Duncan T. McEwan.

The Speaker announced the personnel of Reference Committees and the times and places of their meetings as follows:

I. Health and Education
William H. Proctor, Chairman
Wilbur C. Sumner
James N. Patterson
Michael R. Blais
Maurice M. Greenfield

II. Public Policy
Nelson Zivitz, Chairman
William T. Patton
Albert B. McCreary
Theodore J. Kaminski
David Kirsh

III. Finance and Administration
William C. Roberts, Chairman
William A. Van Nortwick
W. Mahon Myers
Russell B. Carson
Richard C. Clay

IV. Legislation and Miscellaneous
Francis C. Coleman, Chairman
Tim M. Smith
William H. Keeler III
Henry D. Perry Jr.
Franklin J. Evans

V. Medical Economics
J. Maxey Dell Jr., Chairman
West Bitzer
Millard B. White
Harold W. Johnston
James C. Pringle Jr.

Meetings:

I.	2:00 p.m.	Health and Education — Seminar Room #1
II.	2:00 p.m.	Public Policy — Seminar Room #2
III.	2:00 p.m.	Finance and Administration —Seminar Room #3
IV.	2:00 p.m.	Legislation and Miscellaneous—Regency Room
V.	2:00 p.m.	Medical Economics — Card Room

Dr. Edward J. Lauth Jr., of Dade, requested that his name be added as a sponsor of Resolution 68-20 and the request was granted.

Dr. Cook resumed the Chair and asked for the supplemental report of the Committe on Archives.

Dr. Rowland Wood of Pinellas: "This year the Florida Medical Association is honoring those members who joined the Association in the years 1936 and 1937." He asked these members to stand and be recognized and announced there would be a reception for them on Friday, May 10, 1968, at 1:00 p.m. in the Regency Room.

Dr. Wood called attention to the two bouquets of red roses on the podium, one rose for each member who died during the past year. He then said: "A doctor of medicine is not as other men. The nature of his profession permits him to touch his fellow man in ways no other man can. He attends the miracle of birth; he presides at the ritual of death; he eases pain and saves lives; he causes some blind to see and some deaf to hear. He makes some lame to walk and some broken bodies whole. He brings peace to some minds. His knife heals, his medicine cures. He touches lives and makes them happier, longer and more fruitful. Yet, with all this he is unhappy, impatient and intolerant with his meager knowledge. He is constantly in search of more enlightenment. He probes for newer and better methods of as-

sisting his patient to health. He glories in each new discovery and is jubilant at each scientific breakthrough. He recalls the progress of his medical lifetime and is glad.

"Today we honor the memory of those members of the Florida Medical Association who have died in the past year."

Dr. Wood read the roll of those who had died since the last annual meeting, and asked that the House stand for a moment of silent meditation in their memory.

The House stood in silent reverence.

This supplemental report of the Committee on Archives was referred to Reference Committee No. III.

Unanimous consent of the House was given to consider the late report of the Council on Medical Economics and it was referred to Reference Committe No. V.

The Speaker announced that Hillsborough County Medical Association had withdrawn its Resolution 68-10 on Osteopathy.

The Speaker referred to resolutions which had been received too late to be included in the Handbook as follows:

Resolution 68-11 to Reference Committee No. II.

Resolution 68-12 to Reference Committee No. III.

Resolution 68-13 to Reference Committee No. IV.

Resolution 68-14 to Reference Committee No. III.

Resolution 68-15 to Reference Committee No. V.

Resolution 68-16 to Reference Committee No. IV.

Resolution 68-17 to Reference Committee No. V.

Resolution 68-18 to Reference Committee No. I.

Resolution 68-19 to Reference Committee No. IV.

Resolution 68-20 to Reference Committee No. IV.

Resolution 68-21 to Reference Committee No. I.

Unanimous consent of the House was given to consider Resolution 68-22, Violence and Lawlessness, which was referred to Reference Committee No. II.

Unanimous consent of the House was given to consider an emergency resolution, which was given No. 68-23, Wilbur J. Cohen, and was referred to Reference Committee No. II.

The Speaker announced that there would be a 10-minute break before the annual meeting of Blue Shield of Florida. He also called attention to the FLAMPAC luncheon to be held on Friday.

The House of Delegates recessed at 10:50 a.m. to reconvene on Sunday, May 12, 1968 at 9:00 a.m.

Errata

Sorry, we goofed. The following is a correction for error in the May issue of the Journal—Ed.

In the article "Implications of Doctor-Patient Communication, An Investigative Study" by Gary C. Hankins, which appeared in the May Medical Student Research Number of the Journal, the references at the end of the article should be renumbered as follows: References 5, 6 and 7 all comprise reference 5; the remaining references 8 through 21 should be renumbered 6 through 19.

Second House of Delegates

The House of Delegates reconvened at 9:15 a.m. on Sunday, May 12, 1968, in the Regency Room of the Diplomat Hotel, Hollywood, with Dr. James T. Cook, Speaker of the House, presiding.

Dr. William W. Thompson, Chairman of the Credentials Committee, reported 238 delegates registered, which represented a quorum and a majority of the county medical societies, and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA — Henry J. Babers Jr., Billy Brashear, J. Maxey Dell Jr., Walter E. Murphree, William C. Ruffin Jr., I. Irving Weintraub.

BAY — Tim M. Smith, Malcolm M. Traxler.

BREVARD — Jack T. Bechtel, Daniel L. Donovan, Theodore J. Kaminski, Joseph C. Von Thron (Absent —Laudie E. McHenry Jr., Lee Rogers Jr.).

BROWARD — Miles J. Bielek, Russell B. Carson, Yale Citrin, Theodore W. Hahn, David C. Lane, J. Gordon McAllister, Nat T. McGehee Jr., Ray E. Murphy Jr., Henry D. Perry Jr., Lees M. Schadel Jr., Diran M. Seropian, Daniel C. Smith, Robert J. Steinborg, W. Dotson Wells, Scottie J. Wilson (Absent—Gordon B. Carver, Leonard A. Erdman, David J. Lehman Jr.).

CHARLOTTE — Carl N. Reilly.

CLAY — William A. Mulford.

COLLIER — William J. Bailey, Fred A. Butler.

COLUMBIA — Frank E. Adel.

DADE — James L. Anderson, William G. Aten, Thomas J. Baker, George S. Baldry, Jerome Benson, Harvey E. Brown Jr., James B. Byrne, John G. Chesney, Richard C. Clay, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, Donald M. Dooley, L. Washington Dowlen, Franklin J. Evans, Richard M. Fleming, M. Eugene Flipse, Thomas O. Gentsch, Maurice M. Greenfield, Henry C. Hardin Jr., Frank W. Hewlett, Caroline B. Hunter, E. Douglas Hutson, Beverly B. Jones, Walter C. Jones III, James R. Jude, Edward Lauth, Richard E. Litt, Donald F. Marion, Leon H. Mims Jr., Edwin P. Preston, James C. Pringle Jr., M. Murray Schechter, Daniel L. Seckinger II, Everett Shocket, Donald W. Smith, Franz H. Stewart, Chauncey M. Stone Jr., William M. Straight, Charles F. Tate Jr., William B. Welch, Arthur W. Wood Jr., Scheffel H. Wright, Nelson Zivitz (Absent—Morris H. Blau, Manuel L. Carbonell, Chester Cassell, John E. Cunio, O. William Davenport, Marshall F. Hall, David Kirsh, Banning G. Lary, John B. Liebler, Samuel W. Page Jr., Edward W. St. Mary, Thomas W. Skaggs).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL — James L. Borland Jr., Clyde M. Collins, James H. Corwin, Ensor R. Dunsford Jr., Thomas S. Edwards, John J. Fisher, O. E. Harrell, Forrest Haswell, Gordon H. Ira Jr., Charles B. McIntosh, Thad Moseley, Harry W. Reinstine Jr., Wade S. Rizk, Wilbur C. Sumner, J. Champneys Taylor, William A. Van Nortwick, James W. Walker Sr., Jonathan H. Wood.

ESCAMBIA — William M. Colmer Jr., Frank B. Hodnette, Wendell J. Newcomb, William T. Patton, Lockland V. Tyler Jr., William M. C. Wilhoit.

FRANKLIN-GULF — Joseph P. Hendrix.

GADSDEN-LIBERTY — James B. O'Connor.

HIGHLANDS — Donald C. Hartwell.

HILLSBOROUGH — Collin F. Baker Jr., Ernest B. Bourkard, Leffie M. Carlton Jr., Francis C. Coleman, Richard G. Connar, John C. Fletcher, Linus W. Hewit, James M. Ingram, Eugene B. Maxwell, W. Mahon Myers, James N. Patterson, William W. Trice, James A. Winslow Jr., Henry L. Wright Jr.

INDIAN RIVER — E. B. Hardee Sr., James C. Robertson.



JACKSON-CALHOUN — William F. Brunner.

LAKE — Bergon F. Brokaw, J. Basil Hall.

LEE-HENDRY — Wallace M. Graves Jr., H. Quillian Jones Sr., Edward W. Salko.

LEON-WAKULLA-JEFFERSON — James K. Conn, Edward G. Haskell Jr., Nelson H. Kraeft, Alfred L. Lewis Jr.

MADISON — (Absent—Thomas G. Bouland Jr.).

MANATEE — Warren G. Darty, Roger A. Meyer, Joseph F. P. Newhall Jr.

MARION — West Bitzer, Henry L. Harrell.

MONROE — (Absent—Joseph J. Scarlet).

NASSAU — (Absent—Cecil B. Brewton).

OKALOOSA — William W. Thompson (Absent—Andrew F. Giesen).

ORANGE — Axel W. Anderson III, Louis P. Brady, Jesse W. Castleberry, Francis M. Coy, Robert W. Curry, Truett H. Frazier, Paul C. Harding, David Y. Hicks Jr., Harold W. Johnston, Louis C. Murray, Franklin G. Norris, Charles R. Sias, Edward W. Stoner, Miles W. Thomley.

PALM BEACH —Carl E. Andrews, Vernon B. Astler, James F. Cooney, Maximilian A. Crispin, Gabino S. Cuevas, Russell D. D. Hoover, Bernard Kimmel, Bernard F. O'Hara, Nicholas S. Petkas, William H. Proctor, Myrl Spivey, Harold A. Yount.

PASCO-HERNANDO-CITRUS — William H. Hubbard, W. Randall Jenkins.

PINELLAS — William J. Dean, James C. Fleming, David S. Hubbell, Charles A. Johnson Jr., John T. Karaphillis, William H. Keeler III, Charles H. Lasley, Jack A. MaCris, Donald G. Nikolaus, Thomas M. Quehl, John N. Sourbeer, Richard C. Trump, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood (Absent—Joseph A. Ezzo).

POLK — Edward C. Burns Jr., Howard M. DuBose, Spencer Garrett, John W. Glotfelty, Wiley E. Koon, Willard E. Manry Jr., James T. Shelden, Frank Zeller Jr.

PUTMAN — (Absent—Roy E. Campbell).

ST. JOHNS — James J. DeVito.

ST. LUCIE-OKEECHOBEE-MARTIN — John M. Gunsolus, Howard M. McDermid.

SANTA ROSA — (Absent—John P. Merchant Jr.).

SARASOTA — Samuel E. Kaplan, Henry G. Morton, Karl R. Rolls, Millard B. White (Absent—John M. Butcher).

SEMINOLE — Vann Parker (Absent—John M. Morgan).

SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Frederick T. Mickler Jr.).

TAYLOR — James A. Rawls Jr.

VOLUSIA — Michael R. Blais, William E. Carter, Thomas D. Cook, Thurman Gillespy Jr., Charles L. Rickerd.

WALTON — (Absent—McKinley Cheshire Jr.).

COUNCIL ON SPECIALTY MEDICINE — James D. Beeson, Jack H. Bowen, Andre S. Capi, James W. Clower Jr., Charles K. Donegan, Emmet F. Ferguson Jr., David W. Goddard, Joseph G. Matthews, Sanford A. Mullen, Curtis G. Rorebeck, Walter W. Sackett Jr., Edward J. Sullivan Jr. (Absent)—J. Alfred Bowers, Samuel G. Hibbs, Bernard L. N. Morgan).

DELEGATES to AMA — Jere W. Annis, Reuben B. Chrisman Jr., Burns A. Dobbins Jr., Francis T. Holland, Robert E. Zellner.

PAST PRESIDENT AMA— (Absent—Edward R. Annis).

OFFICERS — Jack Q. Cleveland, James T. Cook, Charles K. Donegan, Irving E. Hall Jr., Floyd K. Hurt, George S. Palmer, W. Dean Steward.

BOARD OF PAST PRESIDENTS — Jere W. Annis, Samuel M. Day, H. Phillip Hampton, Ralph W. Jack, John D. Milton, George S. Palmer, Warren W. Quillian, William C. Roberts, William C. Thomas Sr., Leo M. Wachtel, Robert E. Zellner (Absent—Onion O. Feaster, Frederick K. Herpel, Edward Jelks, Walter C. Jones, Francis H. Langley, Duncan T. McEwan, Robert B. McIver, Walter C. Payne Sr., Eugene G. Peek Sr., William M. Rowlett, Joseph S. Stewart).

The Speaker recognized guests from allied professions: Mr. Allen G. Caldwell of the Florida Society of Medical Technologists and Miss Bella J. May, Southeast district chairman of the Florida Chapter, American Physical Therapy Association.

Dr. Steward presented checks for unrestricted grants from the AMA-ERF to Dr. James R. Jude, representing Dr. W. Dean Warren, dean of the University of Miami School of Medicine, in the amount of $3,740.60, and to Dr. Emanuel Suter, dean of the University of Florida College of Medicine, in the amount of $2,369.60.

Dr. Jack Cleveland, President-Elect, introduced Dr. Ernest B. Howard, assistant executive vice president of the American Medical Association.

Dr. Howard said the great challenge to the medical profession today is the preservation of the competitive enterprise, market-oriented approach to the organization, rendition and financing of health care versus the other approach, which can be called the socialization of health care. He mentioned the fact that the government will have in Baltimore a profile of every physician's fees and methods of charging, which may or may not be properly used. The other item he thought most important was the acute supply-demand imbalance—the acute shortage of manpower and the rapidly growing demand. He warned that if this imbalance continues, it will create a very dangerous situation for physicians and will force a restructuring of the practice of medicine. He believed doctors had made a mistake in relinquishing the control of hospitals and urged a return to physician-owned and physician-managed hospital facilities.

Dr. Howard also reviewed the most important of AMA's current programs, requesting the cooperation of all physicians in these programs. In closing, he asked all physicians to take an active interest in politics.

Dr. Cook introduced his wife, Lillian.

The Speaker called for reports of Reference Committees and explained a slight change in the format this year. The AMA method of procedure has been adopted, he said, in which the report of a council, committee or a resolution will be considered as the main motion. The report of the Reference Committee will only recommend whether or not that motion be passed.

Report of Reference Committee No. I
Health and Education

Dr. William H. Proctor, Chairman: "The Committee's recommendations on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee considered the report of the Council on Scientific Activities and recommends that it be approved as printed in the Handbook."

Motion carried.

Council on Scientific Activities

RICHARD C. DEVER, *Chairman*

Council:

The Council met March 17, 1968 to review the activities of its committees and to make recommendations to the Board of Governors to strengthen the scientific activities of the Association.

The Council discussed the question of the study of the Millis Report and noted that no formal action has been taken by the American Medical Association to date to implement any of the proposals in the report. The Council feels that the question of activation of the suggestions in the Millis Report is rapidly becoming overshadowed by the implications for medical education of the Regional Medical Programs (Heart Disease, Cancer and Stroke).

For this reason the Council recommends that the Association sponsor a workshop-type program to permit discussion of the planning and the direction of medical education in Florida at all levels. Those participating would include interested members of the FMA, representatives of the two medical schools in being and the new medical school under development at the University of South Florida, directors of medical education of hospitals within the state, representatives of the Florida Regional Medical Program, and any other persons involved in medical education at the graduate, postgraduate and continuing education levels.

The Council discussed at length the role of organized medicine in postgraduate and continuing education and recommends to the Board of Governors that the role of the Committee on Postgraduate Education be redefined and its purpose clarified in order to permit it to function effectively along with the Committee on Medical Schools in planning continuing education for Florida physicians. The committee feels that its present duties of approving programs seeking FMA sponsorship are perfunctory at best. The growing regional programs and questions of recertification and required refresher courses recently raised across the nation will require careful consideration and study. These questions can be considered at the workshop meeting previously described.

The Council again recommends that the Board of Directors of the Florida Medical Foundation require recipients of research grants to submit reports of progress to the Council on a semiannual basis at least for review by the Committee on Research and the Council. Again the Council recommends that, as well, final results of the research be submitted for inclusion in the Archives of the Association and for consideration by the Journal for publication.

Finally the Council noted the beginning of a dialogue between the Association and the state's medical schools. It is gratifying that mutual problems and proposals can be aired and discussed frankly. It is hoped that these meetings can be held more frequently than in the past, and that they can lead to closer cooperation and mutual support in furthering the objectives of extending medical knowledge, advancing medical science and elevating the standards of medical education.

Committees:

The Committee on the Journal and Other Publications continued its primary function of editing and publishing the Journal, of which some 75,000 copies were printed during the past year. It also continued its program of gradual progression in improving the Journal's over-all quality both as to content and appearance and is pleased to report that the Journal is financially solvent.

The Committee on Medical Schools met jointly March 17, 1968 with representatives of the state's medical schools in what is hoped will be the beginning of a series of similar sessions for exchange of views for the benefit of Florida medicine.



Members of Reference Committee I were Drs. W. H. Proctor, chm., W. C. Sumner, J. N. Patterson, M. R. Blais and M. M. Greenfield.

The Committee on Postgraduate Education continued to review and approve postgraduate education programs for physicians within the state. As indicated earlier, it also concerned itself with a re-evaluation of its role in the light of changing conditions in this area.

The Committee on Research evaluated applications for research grants financed by the Florida Medical Foundation. It expressed concern with inadequate reporting of the results of such research to the profession.

The Committee on Scientific Assemblies during the latter part of 1967 planned and developed the scientific program for the 1968 annual meeting and carried out the many details necessary to its implementation.

Recommendations:

1. That a workshop conference be held under the sponsorship of the Association to consider the implications of the Millis Report and formulate programs applicable to Florida for the various levels of medical education as enumerated in the report, with persons invited to include representatives of the three medical schools, directors of medical education of hospitals, local medical education foundations and programs, and the delegates to the American Medical Association.
2. That the role of the Committee on Postgraduate Education be redefined in the light of rapidly changing conditions in the field of continuing medical education and coordinated more closely with the Regional Medical Program.
3. That the Board of Directors of the Florida Medical Foundation again be requested to furnish semiannual progress reports and final reports on all research projects financed by the Foundation for review by the Committee on Research and the Council on Scientific Activities and publication in the Journal.

Dr. Proctor: "The Reference Committee considered the report of the Council on Specialty Medicine with the following amendments:

"In paragraph 5, item 1—Relative Value Studies—the last line of that paragraph should read as follows:

" . . . Board of Governors that the FMA commence a continuing study, with professional assistance, which will result in annual revisions, deletions and additions in order to keep the RVS current."

Since this subject was also to be considered in Reference Committee No. V, motion was carried to table this portion of the report and consider it when the same subject was brought up in Reference Committee No. V (See report of Reference Committee V, page 665).

Dr. Proctor: "An item 5 should be added as follows:

"In view of objections raised at the Reference Committee hearing to deletions from and editing of reports, the Reference Committee recommends that the complete annual report of all councils submitted to the Board of Governors be published in the Handbook."

Dr. William M. C. Wilhoit of Escambia: "This Handbook is 64 pages. If we followed the recommendation of the Reference Committee, it would be 120 pages and would cost twice as much to print and to mail."

Dr. Franklin J. Evans of Dade: "Let me point out that the authority is now vested in the Board of Governors to edit the reports of committees. If each report was published in its entirety, the cost would be terrific. I recommend that this recommendation of the Reference Committee be disapproved."

Dr. Sanford A. Mullen, Chairman, Council on Specialty Medicine: "The issue here we feel is quite clear. We believe the report of the council should be reflected in the Handbook. We feel it is improper for such a report to be modified by the Board of Governors and published as the report of the Council. If there needs to be a limitation on the number of pages, that could be done in advance. The By-Laws do not state that there be any editing of reports, but only says that reports and resolutions should be published. I believe the attempt to modify any report is not in the best interest of the House of Delegates; therefore, I recommend strongly the support of this recommendation of the Reference Committee."

Dr. Steward, President: "I would like to point out that councils report to the Board of Governors and are responsible to the Board of Governors, and not to the House of Delegates. I would also like to remind you that the complete, unedited report is given to the chairman of the Reference Committee and is available to him in making his decision."

The Speaker called for a voice vote which was inconclusive.

A division of the House was called for; the recommendation of the Reference Committee was not approved.

Dr. Mullen was not satisfied and due to the closeness of the vote requested another division of the House.

The Speaker asked for a voice vote which denied Dr. Mullen's request.

Council on Specialty Medicine

SANFORD A. MULLEN, *Chairman*

Council:

The Council on Specialty Medicine is composed of one-man committees representing each of the 15 major fields of medicine. In addition, the Council has a 26-man subcommittee on specialty groups. These 26 men represent each of the medical specialty societies recognized by the

Florida Medical Association. The 15 Council members are all full voting members of the House of Delegates by virtue of their positions on the Council. The composition of the Council makes it a vital and influential factor in the Florida Medical Association. Members of the Council believe that the comments concerning the Council, which were made in the 1963 Annual Report by its then chairman, Dr. Emmet F. Ferguson, Jr., bear repeating at this time.

> "It is believed that the Council on Specialty Medicine offers an excellent forum for the multifaceted problems of medicine and its specialties and that all members of the Association should communicate such problems to their specialty group for consideration of the Council as a whole. Unity is our strong point, and it is the primary purpose of the Council to nurture this unity, and at the same time to approve any recommendation of any specialty group which benefits medicine as a whole, and to solve the problems of individual groups by the concerted effort of all the specialty groups. It is thought that the group should meet three or four times yearly, and that all representatives should be present if at all possible. It is suggested that each specialty group transmit to the Chairman any items to be placed on the agenda and that this be a continuing process."

The Council has determined that it will meet every three months in the future in order to carry out its responsibilities to Florida medicine. This decision is based in part on the 1963 statement of Dr. Ferguson and in part on the 1967-68 experiences of the Council when it held three meetings (September 9 and December 16, 1967, and March 2, 1968) after a two-year period during which it met only once a year. The three meetings held this year have made the value of regular meetings obvious to all.

The Council has taken part in the following activities during the 1967-68 year:

1. Relative Value Studies—The Council has provided continuing consultation and advice to the Committee on Relative Value Studies as that committee has worked to prepare the 1968 Revision of the FMA Relative Value Study. A recommendation of the Council to the Board of Governors concerning this matter is of major significance and is presented to the House of Delegates for consideration and action. This recommendation was first made at the September 9, 1967, meeting and reaffirmed at the December 16, 1967, meeting. This is quoted as follows: "It was moved and carried that the Council go on record as endorsing the report of the Committee on Relative Value Studies with the knowledge that it is necessary to accept the proposed RVS as a baseline; however, this report is endorsed with the provision that the Council believes strongly and recommends to the Board of Governors that the FMA commence a containing study."

2. Florida Industrial Commission—The Council has pointed out the absolute need to develop an acceptable method for payments to physicians for their professional services in Workmen's Compensation cases. The Board agreed with the Council on this matter and has indicated that it would inform the membership of the FMA to act individually in treating elective workmen's compensation cases if such a plan is not forthcoming in the near future.

3. Legislative Activities—The Council has been informed by the Board that legislative activities by specialty groups should be coordinated with and through the FMA Committee on State Legislation.

4. Informational Forum—The Council has proved to be an excellent forum for disseminating information throughout the FMA membership. Excellent presentations concerning possible changes in the Medical Practice Act and efforts to eliminate the Corporate Practice of Medicine were made by Dr. John J. Cheleden, Chairman of the Judicial Council. FMA legislative activities have also been described to the Council. Problems and difficulties relative to medical schools in Florida have been discussed.

Dr. Proctor: "The Reference Committee was also assigned certain portions of the report of the Board of Governors. The first one was the report on Education, Research, Training and Demonstrations in the Field of Heart Disease, Cancer, Stroke and Related Diseases, P. L. 89-239. The Reference Committee recommends that this be approved and further recommends that a summary of the present status of the Regional Medical Program be submitted by the chairman of the Regional Medical Program for publication in the Journal of the Florida Medical Association."

Motion carried.

Dr. Proctor: "The Reference Committee considered Action No. 6 of the Board of Governors Report — Specialty Societies — and recommends that it be approved as printed in the Handbook."

Motion carried.

Dr. Proctor: "The Reference Committee considered Action No. 15 of the Board of Governors Report — Postgraduate Education — and recommends that it be approved as printed in the Handbook."

Motion carried.

Dr. Proctor: "The Reference Committee considered Action No. 26—Specialty Medicine—of the Board of Governors Report and recommends that it be approved."

Motion carried.

Dr. Proctor: "The Reference Committee further recommends that the communication between all councils and the Board of Governors be improved. [*and to implement this we recommend all meetings of the Board of Governors be held within the confines of the State of Florida in order to encourage attendance by interested parties.*"]*

Dr. H. Phillip Hampton, Past President, moved to amend this recommendation by putting a period after the word "improved" and deleting the remainder of the sentence.

Motion was seconded.

Dr. Hampton: "I am no longer on the Board of Governors, but there are many meetings of the Board during the year within the state, which have easy access for all members who wish to attend. Once a year, the Board of Governors feels it must discuss problems in depth and spend more time, and it has been customary in recent years to retreat to other areas. Expenses of this retreat are not borne by the Association. Often the members take their wives and these trips are at their own expense. To restrict the Board in

*Deleted by House Action.

this manner is rather picayune and as a matter of fact, the attendance by members of the Councils at these meetings has been better than at the in-state meetings."

Dr. Wilhoit: "These meetings are only once a year, the expenses are borne by the members and this is, after all, a captive group in which the members become better acquainted with each other. This was inaugurated by Past President Carnes Harvard and has been followed in that tradition since that time."

Dr. Jere W. Annis, Past President: "I would second the motion of Dr. Hampton and point out to this House that council members, past presidents, have paid their own expenses, so this does not cost the Association anything. We stole this idea from Blue Shield and I was opposed to it at first, but found that they had slyly corralled people into giving two and one half days of their time, and this is a cheap deal for the Association. Secondly, I would submit that perhaps it is not appropriate for the Council on Specialty Medicine to make even a suggestion to the Board on how it carries out its mandates. Certainly it is appropriate that they recommend improved communication, but not to tell the Board they can go to Miami but not to Sea Island, Georgia, and I would urge passage of Dr. Hampton's motion."

Dr. Samuel M. Day, Past President: "As Secretary-Treasurer of the Association at the time this first came up I opposed it and one of the few meetings I ever missed was the first one of these meetings. However, when I saw the work that was accomplished, and the participation and attendance, I came around to that way of thinking. I think it is one of the best things that has been done; it gives enough time to really accomplish something. With the expenses being borne by the members, it adds no more cost to the Association and I would recommend Dr. Hampton's motion be passed."

Dr. Mullen: "I hestitate to speak after such a formidable array of speakers, but I think the House should be informed of the reasoning behind this recommendation of the Council on Specialty Medicine. We have felt that the communications between the Board and the Council have been less than ideal in recent years. We feel it is essential for the Board to be in places that are readily accessible to the members of the Association who have business there. We feel the state of Florida, perhaps unique among all 50, has adequate secluded places in which to meet. If you have to take meetings out of the state or out of the country in order to get them to meet, this is not a very sterling recommendation for our Board.

"I would, therefore, strongly recommend that Dr. Hampton's amendment not be passed and that the recommendation of the Reference Committee be approved."

Dr. John J. Fisher, Duval: "I would like to support Dr. Mullen. If we were the medical society of Tennessee or Montana there might be some excuse for going out of state, but it looks bad for the state medical association to go out of state, and I think we lose more by such action than the members of the Board could possibly gain."

Dr. James D. Beeson, Council on Specialty Medicine: "We have no objection to where the Board of Governors conducts its fraternal meetings; we merely ask that when they conduct the official business of the Florida Medical Association they do so within the state so other members may participate or observe."

Dr. Walter W. Sackett Jr., Dade: "Despite the argument that the members pay their own expenses, I am sure there is a huge expense for members of staff, setting up meetings and carrying all the paraphernalia that goes with a big meeting, when all the material is back in Jacksonville. I am sure there are times when you need material which is back in the office. There is no branch of government that holds meetings outside its legislative area, and I would propose therefore that we oppose this amendment."

Dr. Michael R. Blais, Volusia: "I believe in keeping Florida green; I believe in spending your money where you make it with the people who pay our fees, and as a member of this committee this was my basic reasoning and I still think it is sound reasoning."

Dr. Wilbur C. Sumner, Duval: "In discussion of this, we were not trying to inhibit the personal actions of any member of the Board of Governors; however, it was obvious that communication between the Board of Governors and the councils had not been good. This is one of the reasons the committee requested that complete reports be recorded in the Handbook so that all delegates would know what was going on. This was the reason this committee made this request of the Board of Governors."

Dr. M. Eugene Flipse, Dade: "If we carry this to its logical conclusion, none of us will go

to the mountains this summer, none of us will slip across to the islands to go fishing: I think there is no problem of communication, as we are all able to get into the Board of Governors meetings and be heard. The distance between Jacksonville and Sea Island is less than between Miami and Jacksonville: the distance between Palm Beach and Grand Bahama is less, and I don't think it is appropriate to restrict our Board of Governors."

Dr. Steward, President: "First of all, I would like to say that some of the Council members this year told me that communications between the Board and the councils were better than ever before. The attendance of council chairmen at Jacksonville meetings has not been overwhelming. Those who come frequently present some brief item and then leave; they do not stay for the whole meeting. When we go anywhere for a retreat, they are more or less a captive audience and they attend, and the attendance of council members at a retreat has always been better than at any Saturday or Sunday meeting in Jacksonville.

"The question was brought up of the expenditure of the Association's funds for staff. Not once have we even taken so much as a secretary. Mr. Parham goes and with the assistance of Dr. Hurt takes the notes, and this is the only paid member of the Florida Medical Association staff that costs the Association anything for the trip other than room and board which they would have anywhere. I think some of the members seem to feel that the Board of Governors is not capable of carrying on their business and is not to be trusted with their finances, and I think this really gets down to a vote of confidence."

Motion carried.

Dr. Steward thanked the House for its reaffirmation of confidence in the Board.

Dr. Proctor: "The Reference Committee considered Action No. 27 (Medical Education, Statement of Policy) of the Board of Governors Report and recommends that it be approved as printed in the Handbook."

Motion carried.

(See Board of Governors' Report, page 647.)

Dr. Proctor: "The Reference Committee considered Resolution No. 68-5, Finger Surgery Technique, and recommends adoption with the following amendment to the last line of the first paragraph of the resolution: 'this method is not medically acceptable. Further be it' "

Motion carried.

Resolution 68-5

"Finger Surgery Technique"
West Bitzer, Delegate

It is hereby RESOLVED, That the Florida Society of Otolaryngology go on record as being opposed to payment of state and/or federal funds for treatment of patients by the "Muncie" method or "finger surgery technique" for cure of deafness, irrespective of type or cause, as it is the opinion of competent otologists that this method is not medically acceptable. Further, be it

RESOLVED, That copy of this resolution be sent to all Congressmen and Senators representing the State of Florida in our Federal government.

This resolution, when approved, will be sent through the proper channels of the Florida Medical Association for action.

Dr. Proctor: "The Reference Committee considered Resolution No. 68-18, Chemical Face Peeling, and recommends that it be approved as submitted."

Motion carried.

Resolution 68-18

Chemical Face Peeling
Dade County Medical Association

Whereas, Chemical face peeling is an accepted medical treatment used to treat disease, including various skin disorders and the process of aging, and

Whereas, This procedure requires constant and expert medical supervision, and

Whereas, Chemical face peeling by "lay operators" in some instances has resulted in permanent disfigurement and even death; now therefore be it

RESOLVED, That the Board of Governors of the Florida Medical Association take every possible action, through the legislature or the Florida Board of Medical Examiners, to establish that chemical face peeling is the practice of medicine and is to be regulated as such.

Dr. Proctor: "The Reference Committee considered Resolution No. 68-21, Antibody Rubella Screening Tests, and recommends adoption with the following amendment beginning with resolved:"

RESOLVED, That the Florida Medical Association request the Florida State Board of Health to perform on request the Rubella Antibody Screening Test (either Fluorescent Antibody, Hemagglutination Inhibition or Complement Fixation) on those specimens submitted for serologic examination until private facilities for doing this are available.

Motion carried.

Resolution 68-21

Antibody Rubella Screening Test
John M. Gunsolus, M.D., Delegate

Because Antibody Rubella Screening Tests are unavailable to most areas in Florida:

RESOLVED, That the Florida Medical Association request the Florida State Board of Health to perform on request the Rubella Antibody Screening Test (either Fluorescent Antibody, Hemagglutination Inhibition or Complement Fixation) on those specimens submitted for serologic examination until private facilities for doing this are available.

Dr. Proctor: "The chairman wishes to express his appreciation to the members of his committee, Drs. Blais, Patterson, Greenfield and Sumner and also to our secretary, Miss Louria Neel, and to the members of the Association—those hornets who came to our nest.

"This concludes the report of Reference Committee No. I."

The Speaker announced that for the convenience of a guest he would now interrupt the reports of reference committees.

Dr. Walter W. Sackett Jr., Dade, introduced The Honorable Richard A. Pettigrew, Representative from Dade County.

Mr. Pettigrew: "We are very pleased in the House and the Senate to have two doctors in each body. It has been a tremendous asset to us to have reliable medical information, people with adequate training in medicine, to advise us on a person-to-person basis within the legislature. As you know, more and more public policy decisions are going to determine the course of the medical profession and medical services, and it is absolutely indispensable in my judgment that more and more doctors participate as elected officials.

"It has been a tremendous program on the part of the Florida Medical Association to have serviced the dispensary. As a member of the House administration committee I have arranged for greatly enlarged quarters. We need your services. Last year we had 143 days away from our homes serving in regular and special sessions. At $100 a month this is a good bargain for the people, but legislators do get ill and they need assistance daily. It has been very meaningful to us to have 60 doctors come from all over the state to give their services at the dispensary. We hope you will enlarge your participation in the coming sessions.

"Now, Dr. Steward, I would like to present to you House Concurrent Resolution No. 299X-68, signed by the speaker of the House, Ralph D. Turlington, the president of the Senate, Verle Pope, and the Governor, Claude Kirk, and I will read it."

House Concurrent Resolution No. 299-X(68)

A concurrent resolution commending the establishment of a dispensary for the benefit of members of the Legislature.

WHEREAS, the health of members of the Senate and of the House of Representatives of the State of Florida has been materially benefited by the establishment of a medical dispensary in the Capitol building during the regular and special sessions of 1967 and 1968; and

WHEREAS, the establishment of this dispensary was initiated through the efforts of the membership of the Florida Medical Association; and

WHEREAS, some sixty members of this Association, along with medical members of the Senate, Dr. Lane and Dr. Fisher, as well as those of the House of Representatives, Dr. Hodes and Dr. Sackett, have voluntarily contributed their medical knowledge and skill to this aforementioned purpose; and

WHEREAS, the integration and supplementation of these services have been furthered by various Leon county members of the Florida Medical Association, and in particular, Dr. Edward Haskell, NOW THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF FLORIDA, THE SENATE CONCURRING:

Do now commend and extend an expression of heartfelt thanks for the efforts of the Florida Medical Association and its individual members, and,

BE IT FURTHER RESOLVED that it is the sincere feeling of the House of Representatives of the State of Florida, the Senate concurring, that these services have been an invaluable contribution to the efficiency of both Houses and that it is the hope that such services will be available during future sessions.

ORIGINATED in the House; adopted by the House on February 16, 1968 and has been examined and found to be correctly enrolled.

Signed:

Ralph D. Turlington
Speaker of the House of Representatives

Allen Morris, Clerk, House of Representatives and Ex-Officio Enrolling Clerk

Adopted by the Senate on February 16, 1968

Verle Pope, President of the Senate

Edwin J. Straser, Secretary of the Senate and Ex-Officio Enrolling Clerk

Approved this 5th day of March 1968

Claude Kirk, Governor

Filed in Office of the Secretary of State on March 6, 1968

Tom Adams, Secretary of State

"Dr. Steward, we greatly appreciate the efforts of the Association."

Dr. Steward: "Mr. Pettigrew, on behalf of the Florida Medical Association I thank you for this unique honor by our legislative body."

Dr. Sackett: "And to think, just one session ago, both houses were saluting a naturopath as being the doctor of the legislature."

Report of Reference Committee No. II
Public Policy

Dr. Nelson Zivitz, Chairman: "The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The Reference Committee approved the report of the Council on Allied Professions and Vocations."

Motion carried.

Council on Allied Professions and Vocations

JESSE W. CASTLEBERRY, *Chairman*

Council:

The Council held one meeting during the past Association year, October 22, 1967, and considered various committee reports as follows:

Committee on Law—Although the proposed Florida Professional Medicolegal Code was passed by the FMA House of Delegates in 1965, it was determined that the Florida Bar had not as yet taken action on the Code. William P. Simmons Jr., president of the Florida Bar, was contacted by phone and letter and through his efforts Mr. Chester Bedell, chairman of the Trial Lawyers Section of the Florida Bar, was contacted and in a letter of January 1, 1968 stated that the matter has been referred to the Florida Bar Civil Law Committee and would be on the agenda of the Florida Bar Executive Council meeting of January 6. No further information has been forthcoming; however, it is believed that the Medicolegal Code will be reviewed by the Florida Bar and that further information as to any action taken will be forthcoming.

Committee on Medical Assistants—The Committee had been asked to discuss, in its capacity as advisory board to the Florida Medical Assistants Association, organizational problems within tbe FMAA. After discussion and review of actions taken by the FMAA and by several of its individual members, the Committee transmitted to all members of the FMAA Executive Board its recommendations for solution of the problems.

The Committee also discussed the proposed licensure of paramedical personnel by the State Board of Medical Examiners in relation to medical assistants. In light of the fact that a certification program is offered by the American Association of Medical Assistants, the Committee was of the opinion that licensure of medical assistants is not desirable at this time.

Committee on Nursing—After several meetings between and conversations among members of the FMA Committee on Nursing and the Florida Nurses Association Liaison Committee, the First Florida Medical Association-Florida Nurses Association Conference, to be entitled "New Horizons in Nurse-Physician Relations," is scheduled for June 8-9, 1968 at the Robert Meyer Motor Inn, Orlando. The meeting will be closely patterned after the three national physician-nurse conferences that have been sponsored by the American Medical Association. It is hoped that all attending the conference will be inspired to continue close liaison between their respective professions on a local level.

Committee on Physical Therapy—A conference regarding the training and education of physical therapy assistants was held February 3, 1968 and was attended by representatives of the FMA, State Department of Education, State Board of Medical Examiners, American Physical Therapy Association, Florida Chapter, and members of various rebabilitation centers throughout the state. It was mutually agreed that the principles evolved from the conference will set a valuable precedent in that a framework for continued consultation between the Department of Education and members of the medical and paramedical professions was established. This framework consists of appointment by the Department of Education of an ad hoc committee consisting of a member or members from the paramedical profession, State Board of Medical Examiners, involved educational institutions and the FMA Council on Allied Professions and Vocations to work with the Department in setting forth curriculum guidelines for the training of particular paramedical personnel, said guidelines to be later reviewed by the FMA and the Board of Medical Examiners.

Committee on Religion—The various committees on medicine and religion held meetings in their respective societies during the past year. A meeting of the county chairmen of the respective county medical societies was held in Orlando, January 27, 1968 in conjunction with the 10th Annual Conference of County Medical Society



Serving as Reference Committee II were Drs. N. Zivitz, chm., W. T. Patton, A. B. McCreary, T. J. Kaminski and D. Kirsh.

Presidents and Secretaries. We were fortunate in having with us the Rev. Dr. Paul B. McCleave, Director of the Department of Medical and Religion of the American Medical Association. Open discussion was held and Dr. McCleave was most helpful in the advice he rendered to us. It is hoped that there will be an increasing interest in the field of medicine and religion in the various counties during the coming year. We have arranged to have an exhibit on medicine and religion at the FMA Annual Meeting in May.

Committee on Veterinary Medicine—Dr. Hiram C. Polk of Miami was appointed to succeed Dr. Clifford Snyder as chairman of the committee. During the past Association year, the relationship between Dr. Snyder and Robert Knowles, D.V.M., continued to be very productive with additional work in the field of tracheomalacia, a common disease in dogs. Dr. Snyder was able to devise a procedure which has been helpful in the management of this illness and which has been recently demonstrated and discussed at the national meeting of Canadian veterinarians. Despite the effectiveness of Dr. Snyder and Dr. Knowles' relationship, it seems that the activities of this committee have been primarily on a one-to-one and relatively unilateral basis. This situation has been discussed with Dr. Knowles and it is mutually thought that discussions of problems in human and veterinary medicine among larger groups of persons might be one solution. The committee proposes that such a roundtable discussion be held at the time of regional and statewide veterinary meetings and that physicians interested in areas of likely benefit be present. The good will and effective relationship established between Dr. Snyder and Dr. Knowles should be expanded to the medical and veterinary professions as a whole.

Recommendations:

1. That licensure of professional paramedical personnel whose services under the law require the prescription of a physician be included under the purview of the State Board of Medical Examiners in a manner similar to the licensure of physical therapists and physical therapy assistants.

2. That professional paramedical personnel whose licensure is otherwise presently provided for under Florida law be excluded from licensure supervision of the Board of Medical Examiners at this time.

3. That responsibility for liaison with inhalation therapists be removed from the Committee on Physical Therapy and be placed under the Committee on Nursing.

4. That the name of the Committee on Physical Therapy be changed to the Committee on Physical Therapy and Rehabilitation Therapists to indicate that committee's full responsibilities.

5. That the problem which has developed in Leon County regarding occupational therapists and speech therapists not having received payment to which they were entitled under Medicare be referred to the Council on Medical Economics for possible consideration by the Committee on Advisory to Blue Shield and Fiscal Intermediaries.

6. That the FMA endorse the principles for consultation on training of all paramedical personnel evolved at the State Department of Education Conference on Physical Therapy Assistants held February 3, 1968 in Tallahassee.

7. That the FMA endorse the establishment of an additional school for the training of physical therapists in association with the new medical school at the University of South Florida and further that it recommend and encourage the expansion of the existing school for the training of physical therapists at the University of Florida.

8. That every county medical society be encouraged to have a functioning Committee on Medicine and Religion.

9. That the recommendations approved by the Committee on Nursing and the Board of Governors be adopted as FMA policy (See Board of Governors Report, Action Number 25).

Dr. Zivitz: "The Reference Committee approved the report of the Council on Medical Services as printed in the Handbook."

Dr. Lauth rose to a point of order and pointed out that the subject of therapeutic abortion also was considered in Reference Committee No. IV. He moved that this be tabled until this subject was brought up in the report of Reference Committee No. IV.

Motion carried to table this portion of the report.

Motion carried to approve the remainder of the report.

Council on Medical Services

JAMES M. INGRAM, *Chairman*

Council:

As is its usual custom, the Council held two meetings during the past Association year: September 24, 1967, and March 10, 1968. Both meetings were held in Orlando. At the former meeting, plans for future committee activities were formulated, reviewed and approved. The latter meeting was for the purpose of evaluating and accepting recommendations to be included in the Council's 1967-68 annual report.

Although the effectiveness of the Council as an entity has been questioned in the past in view of the diversified functions of its 13 committees, its considerable value as a coordinating and broadening body is now undisputed. Meetings of the Council are educational experiences for each member in the wide variety of problems and progress in the delivery of health care to the public.

To the extent of their individual functions, all of the committees of the Council were active during the year. The one exception, the Committee on Labor, was permitted an inactive status unless and until problems between organized labor and medicine in the state arise, an action which was approved by the Board of Governors.

Detailed individual committee reports are too voluminous for inclusion in the Council report, but are available upon request. In brief, the Committee on Aging revised and refined a series of objectives for its activities, continued to represent the Association on the Florida Joint Council on Health of the Aging and concerned itself with strengthening medical participation and representation in official and voluntary groups in this field. The Committee on Blood spent considerable time studying the difficult legal problem of the salability of blood and the Florida operations of a serum research firm which carried potentially serious ramifications for the practice of medicine.

The Committee on Child Health continued its major efforts as School Health Medical Advisory Committee to the State Department of Education and State Board of Health, in which capacity it developed numerous policies

and recommendations utilized by the state agencies in administering Florida's school health program. The Committee on Emergency Medical Service kept abreast of national and state developments in emergency and disaster care, and continued its other role as state medical advisory committee to the Selective Service System, in which as of March 1, 1968, 60 physicians were processed for duty with the armed services, of whom 24 were declared essential or deferred.

The Committee on Hearing worked in an advisory capacity in implementation of the new state hearing aid dealers law and continued its efforts to implement a statewide hearing testing program in the public schools. The Committee on Maternal Health refined and expanded its continuing maternal mortality study and worked toward passage of a revised state therapeutic abortion law. It also studied Florida's birth and death certificates and recommended necessary revisions.

Implementation of the community-oriented mental health program received considerable attention from the Committee on Mental Health. Its efforts to achieve better coordination of all state mental health, mental retardation and correctional activities were strengthened with its highly successful sponsorship of the 1968 Annual Conference of Key State Mental Health Leaders, held February 25 in the FMA headquarters building in Jacksonville. The Committee on Mental Retardation worked closely with the State Division of Mental Retardation to improve and expand institutional and community services to the mentally retarded.

The Committee on Occupational Health continued to work toward the inclusion of instruction in occupational and industrial health in the curricula of the state's medical schools. The Committee on Public Health studied and provided advice on a variety of matters generally considered in the area of public health. It developed significant recommendations for Association objectives and activities concerning health care for the poor.

The Committee on Rural Health continued to represent the Association on the seven-organization joint Florida Committee on Rural Health and maintained close liaison with rural and farm groups. It developed a series of recommendations in its area. The Committee on Vision devoted effort to studying the practice of optometry in the state and also concerned itself with the visual aspects of automobile accidents and vision standards for drivers.

It should be pointed out that because of timeliness, several recommendations of the Council and its individual committees were presented directly and previously to the Board of Governors and therefore they will not appear in this report. These recommendations had to do with the role of the Committee on Labor, the possibility of a state perinatal mortality survey, the Broward County "Teenage Alert" program, the possible inclusion of birth defects information on the Florida birth certificate, the retention of a State Board of Health in a revised state constitution, Association activities in the area of health careers recruitment, Association policies and programs relative to health care for the poor, and action by the Governor on the education and tax legislative "package."

All of the following consecutively numbered recommendations have been carefully reviewed and adopted by the Council. To facilitate the procurement of necessary additional background information, the name of the originating committee or committees precedes each recommendation or series of recommendations.

Recommendations:

(Committee on Aging)

1. That interest in the field of geriatrics be promoted through educational channels such as the presentation of special programs at county medical society meetings and at the FMA annual meeting rather than by working toward the establishment of geriatrics as a medical subspecialty.

2. That the Association continue to support and participate in the activities of the Florida Joint Council on Health of the Aging.

3. That the chairman and members of the Committee on Aging and/or other Association members be urged to become active in and accept appointments to appropriate committees of the Florida Council on Aging.

4. That medical representation on the Florida Commission on Aging be reviewed and the officers and Board of Governors be requested to make appropriate nominations to the Governor to assure adequate medical representation on this body.

(Committee on Blood)

5. That the Association sponsor and/or support blood banking legislation during the next regular session of the Florida Legislature that would clarify the implied warranty of blood supplied by blood banks and hospitals.

(Committee on Maternal Health)

6. That the Association support the further extension of public funds for family planning activities and programs in the indigent population as implemented by the Bureau of Maternal and Child Health of the Florida State Board of Health.

7. That provision for a yes or no answer to the statement "Pregnant or pregnancy terminated in the last 90 days" be added to the Florida death certificate.

8. That the U. S. Standard Certificate of Live Birth (January 1968 revision) be adopted in Florida.

(Committees on Maternal Health and Mental Health)

(9. That revised therapeutic abortion legislation be introduced in the next regular session of the Florida Legislature—Tabled).

(Committee on Occupational Health)

10. That the University of Florida College of Medicine, the University of Miami School of Medicine and the new medical school under development at the University of South Florida be urged to include instruction in the area of occupational health and industrial medicine in their curricula for medical students.

(Committee on Public Health)

11. That the Association reemphasize earlier recommendations calling for provision of a State Board of Health in any revised Florida Constitution.

12. That county medical societies be urged to take leadership in initiating programs in their areas for comprehensive health planning to achieve coordination of all health related activities and services.

13. That the venereal disease case finding project among migrant agricultural workers be

continued by the Florida State Board of Health for an additional year.

(Committee on Rural Health)

14. That the Association support and implement the program aimed at improving rural emergency medical services initiated by the American Medical Association Council on Rural Health and approved by the AMA Board of Trustees and the Florida Committee on Rural Health.

15. That first aid courses be required in all county school systems and that efforts be made to have at least one person in every rural home trained in first aid.

16. That all immunization programs be actively implemented with special emphasis upon tetanus and measles.

17. That efforts be made to hold soil and water pollution in rural areas to the minimum extent possible through public education concerning approved preventive measures.

18. That a long range program be developed to help make family physicians more easily accessible to citizens residing in rural areas.

Dr. Zivitz: "The Reference Committee recommends approval of the Report of the Council on Voluntary Health Agencies as printed in the Handbook."

Motion carried.

Council on Voluntary Health Agencies

MASON ROMAINE III, *Chairman*

Council:

Official meetings of the Council were held May 27, 1967 and February 17, 1968. The former meeting was devoted to planning and implementation of practically every facet of the Council's activities, while the latter session primarily was for the Council's annual joint conference with the executive directors of recognized Florida voluntary health agencies. An additional meeting is scheduled for May 4, 1968, at which time a conference will be held with officers of Leukemia Society of America, Inc., concerning that organization's pending application for recognition.

Although there are no new recommendations made in this report, the Council remained quite active during the year in concerning itself with a variety of subjects related to its basic purpose of maintaining close liaison with voluntary health agencies and assuring adequate medical participation in their programs in the public interest.

The brief summary of the Council's 1967-68 activities which follows is presented by general subject area.

Recognition Program—With emphasis upon the medical aspects, the programs of the eleven statewide voluntary health agencies officially recognized by the Association were carefully reviewed and re-evaluated, as is the annual custom. No reasons were found for recommending withdrawal of recognition for any of the eleven, but several which furnished inadequate information were warned that their recognition might be jeopardized. New applications from several organizations were received and considered. In each of these cases, it was decided the group did not yet qualify as a statewide voluntary health agency and therefore was ineligible for evaluation at this time. As earlier noted, one application, that of Leukemia Society of America, Inc., is under study. Of the Florida voluntary health agencies considered of statewide scope, only one has not applied for recognition to date. One other applied a number of years ago, but did not pursue the application when requested to furnish additional data. The following organizations currently are recognized:

Florida Chapter, Arthritis Foundation
Florida Society for the Prevention of Blindness
Florida Division, American Cancer Society
United Cerebral Palsy of Florida
Florida Society for Crippled Children and Adults
Florida Heart Association
Florida Association for Mental Health
National Multiple Sclerosis Society
The National Foundation
Florida Association for Retarded Children
Florida Tuberculosis and Respiratory Disease Association



Rapt attention was the order of the day at the Friday scientific sessions.

Liaison with Agency Executive Directors—As indicated earlier, tbe Council beld its annual joint conference with the executive directors of recognized agencies February 17, 1968, witb all but two agencies represented. The conference was probably the most productive session in the series. Lasting nearly five hours, it also set a record for longevity. Among the many subjects discussed were the overlapping of services to crippled and retarded children, the possibility of a coordinated educational program for agency staff and volunteers, the use of FMA recognition, possible educational courses for medical students concerning voluntary health programs, the acceptance of federal funds by voluntary agencies, United Funds and United Health Foundations and their effects on the voluntary health movement, Comprehensive Health Planning and Regional Medical Programs, education of practicing physicians in voluntary health activities, and the role of voluntary health agencies in stimulating county medical society programs.

Florida Voluntary Health Association—The Council maintained close liaison with the Florida Voluntary Health Association, the joint state coordinating body formed in 1966 by all but one of tbe statewide voluntary healtb agencies. The association has undertaken an ambitious program of activities of benefit to the voluntary agencies such as legislative action, preparation of a directory of Florida health services and organizations, sponsorship of educational programs including the annual Institute for Voluntary Health Agencies, and encouragement of similar local coordinating groups. Its program has been hampered during the latter part of 1967 and early 1968 by tbe loss of the association's first executive secretary, wbo was part-time and resigned to take a full-time position outside the health field. A replacement has not been found to date. Perhaps the group's most significant accomplishment is the recent formation of several local voluntary health agency coordinating councils.

County Medical Society Programs—During the summer of 1967, the Council mailed out a packet of materials to all Florida county medical societies. The purpose of the packet was to encourage local societies to undertake similar programs to that of the state association. In response to the mailing, some ten societies notified the Council of the names of chairmen of committees which had been given this responsibility. These chairmen were invited to attend and participate in the Council's February meeting, but only three actually attended, two of whom were members of the Council who also served as local cbairmen. The Council is not discouraged with this showing and believes that witb increased and continued educational and communications efforts, this new program will gradually expand.

Charitable Solicitations Act—Througb the efforts of the Secretary of State, tbe major voluntary health agencies and the Council, revisions improving the Florida Charitable Solicitations Act passed tbe 1967 session of the state legislature. In brief, these amendments provide for registration of professional solicitors, relief for small organizations relative to auditing requirements, exemption for certain civic groups and clarification of filing by parent organizations. The Council continues to be represented in the membership of the Secretary of State's advisory committee for administration of this law.

United Funds—During the year, the Council has maintained continuing study of the medical programs of United Funds-United Health Foundations on national, state, and local levels, with particular emphasis upon the effects of these programs upon the entire voluntary health movement.

Comprehensive Health Planning and Regional Medical Programs—Tbe Council has furtber studied and will continue to maintain surveillance over the possible effects of Comprebensive Healtb Planning, Regional Medical Programs and other federally financed health programs upon the voluntary bealtb agencies.

AMA Program—Close relations bave continued between tbe American Medical Association Council on Voluntary Health Agencies and the FMA Council tbrough the membership of tbe cbairman on both councils. National activities have been reported regularly to the Council.

Dr. Zivitz: "The Reference Committee recommends approval of **Board of Governors' Action No. 10, Ambulance Service** as printed in the Handbook."

Motion carried.

Dr. Zivitz: "The Reference Committee considered Board of Governors' **Action No. 25 on Nursing.** The Committee was in complete agreement with the goal of upgrading nurses' training, but wished to avoid a prolongation of training and economic difficulties in selective situations. The Committee recommends adoption of this action with the following amendment:

"The Board approved the recommendation of the Committee on Nursing that efforts be made to enlarge classes in the present baccalaureate nursing programs in Florida; to preserve the remaining diploma (two and three year) schools of nursing and to reestablish others; that an extra year of in-hospital on-the-job training for all graduate nurses be encouraged; that all programs for nurse training stress more clinical and bedside nursing; [*that the FMA sponsor a resolution to the AMA that action be taken to stimulate additional funds for nursing education,**] and that the FMA go on record as recognizing the nurse as a member of the professional health team, deserving the respect and help of all FMA members and deserving a salary commensurate with knowledge and experience."

Dr. Evans, Dade: "It is my belief that we have recognized the nurse as a member of the professional health team a long time ago. I move that the word "recognizing" be changed to "reaffirming."

Motion was seconded and carried.

Dr. Reuben B. Chrisman Jr., AMA Delegate: "Point of information. In asking to stimulate additional funds—I assume these are private funds or endowed funds, not government funds?"

Dr. Zivitz replied, "Governmental funds."

Dr. Sias moved to insert the word, "private."

Motion was seconded.

Dr. Rowland E. Wood, Pinellas: "We have a very fine nursing school in St. Petersburg which is a part of the Junior College. This is government funds. I think they need government as well as private funds."

Dr. James M. Walker, Chairman, Committee

*Deleted by action of the House.

on Nursing: "I would like to see both words inserted, 'government and private.' The AMA has gone on record as supporting federal legislation for the nursing training act and I think we should back it up."

Dr. Robert E. Zellner, Past President: "This is a nebulous resolution that doesn't say much except we are in favor of nurses. The Florida delegates have a difficult time taking resolutions to the House of Delegates of the AMA when we don't know exactly what you want. Often these things are redundant and I can assure you that the House of Delegates of the AMA is very much in favor of increasing nurses throughout the United States. At the last session, such a resolution was passed. If the FMA wants to pass such a resolution, that is fine, but it doesn't do any good for the AMA to pass such a resolution at every session. You diminish the influence of your delegates when you ask them to take a motherhood type resolution, or one that has already been passed. This recommendation is totally unnecessary.

"I move that reference to taking this to the AMA House of Delegates be deleted. It is unnecessary; it has already been done."

Motion seconded.

Dr. William G. Aten, Dade: "If the motion is redundant, I agree. However, I feel strongly that this should be only endowment of private funds. We do not need to get more government into nursing education and medical education."

Dr. Holland rose to read the resolution which was passed by the American Medical Association last year.

This was accepted as information.

Motion was carried to amend the Reference Committee report as stated by Dr. Zellner. This also deleted the amendment to insert the word "private."

Motion carried to approve the recommendation of the Reference Committee as amended.

(See Board of Governors' Report, page 647)

Dr. Zivitz: "The Reference Committee considered **Resolution 68-3, Non-Medical Groups Sponsoring Preventive Medical Immunization Programs,** Lake County Medical Society, and recommends that it be adopted with the following amendments:

"Items 2 and 3 of the 'RESOLVED' should read as follows:

"2. The County Medical Society will be recognized as co-sponsor of such programs if it so desires.



Shown receiving guests at the President's Reception are (from left) Mrs. Steward, Dr. Steward, Mrs. Cleveland and Dr. Cleveland.

"3. All profits derived from such programs will be donated to an education or research foundation or to initiate or conduct a similar project."

Motion carried.

Resolution 68-3

Non-Medical Groups Sponsoring Preventive Medical Immunization Programs Lake County Medical Society

Whereas, It has become increasingly popular for Service groups such as Junior Chamber of Commerce and other Service Groups to sponsor programs which render medical care to the general populace, as the polio and measles vaccine immunizations programs, and

Whereas, These programs generally are initiated with Good Samaritan principles upon the part of the sponsoring agency, and

Whereas, These sponsoring agencies charge fees or receive donations for these services rendering them not truly philanthropic, which could allow certain groups to utilize these programs for other than Samaritan purposes; therefore, be it

RESOLVED, That the Florida Medical Association, which has no fixed policy regarding these programs establish policies. That these policies be:

1. Approval from the County Medical Society and community physician involved is necessary for any of these programs.
2. The County Medical Society will be recognized as a co-sponsor of such programs if it so desires.
3. All profits derived from such programs will be donated to an education or research foundation or to initiate or conduct a similar project.

Dr. Zivitz: "The Reference Committee considered **Resolution 68-11, Certificate of Good Health and Certificate of Premarital Examinations.** The Committee considered that this resolution presented multiple problems in health, medical-legal and administrative areas requiring intensive studies. For this reason the Committee recommends that this resolution be referred to the Board of Governors for further study, this study to include all forms of *compulsory** health certificates."

*Changed to "governmental" by House action.

Dr. Flipse moved to delete the word "compulsory."

Motion seconded and carried.

Dr. Sackett moved to insert the word "governmental" in place of the word "compulsory."

Motion carried.

Motion carried to approve the resolution as amended.

Resolution 68-11

Certificate of Good Health and Certificate of Premarital Examination
Walter W. Sackett Jr., M.D., Delegate

(Approved—Referred to Board of Governors)

Whereas, The Certificate of Good Health issued by the State of Florida and the Certificate of Premarital Examination likewise so issued call for specified laboratory tests, and

Whereas, Each of these certificates has a portion in which a licensed physician certifies that he has examined the patient, and,

Whereas, Often times a laboratory will procure a physician to sign the certificate which bears the statement "I have examined the person," even though he has not so done, and

Whereas, It is the practice of the physicians in various units of the Public Health Department of the State of Florida to sign these certificates without benefit of examination, and

Whereas, The value of these certificates in regard to the function they purport to fulfill is of a dubious nature: Now, therefore, be it

RESOLVED, That the Florida Medical Association go on record as follows:

1. That these forms be reworded in such a way that would relieve any signing physician of the charge of perjury for not fulfilling the statement of performance on the certificate, or
2. That the present law be retained and enforced in accordance with its specific provisions, and be it further

RESOLVED, That the scientific purposes of these tests mentioned on the certificates be investigated as to whether or not they do perform a proper and needed function.

Dr. Zivitz: "The Reference Committee recommends approval of Resolution 68-22, Violence and Lawlessness, as submitted at the first meeting of the House of Delegates and recommends that it receive all possible publicity."

Dr. Charles F. Tate Jr., Dade: "I would like to move to add to this resolution:

"And Resolved, that copies of this speech by The Honorable Marshall M. Criser, President-Elect of The Florida Bar, made to this House on May 9, be made available to all physicians for use in their offices for distribution to their patients."

Motion carried.

Motion was carried to approve the resolution as amended.

Resolution 68-22

Violence and Lawlessness
Louis P. Brady, M.D., Delegate

Whereas, Mob violence and lawlessness continues to increase at an alarming rate presenting a clear and present threat of destruction of the democratic process;

Whereas, The Florida Bar Association president has chosen to emphasize this fact in his guest address to the Florida Medical Association House of Delegates; therefore be it

RESOLVED, That the Florida Medical Association reiterate its recognition and by all of its resources continue to promulgate these facts to our patients and the general public; and be it

RESOLVED, That the delegates to the AMA be instructed to introduce a similar resolution at the next annual meeting; and further be it

RESOLVED, That copies of this speech by The Honorable Marshall M. Criser, President-Elect of The Florida Bar, made to this House on May 9, 1968, be made available to all physicians for use in their offices for distribution to their patients.

Dr. Zivitz: "The Reference Committee considered Resolution 68-23, Wilbur J. Cohen, submitted at the First House of Delegates. This Committee recognizes the desire to express a dissenting opinion whether or not this expression is effective. However, a recommendation is made that offers a more positive and direct approach to the main problem.

"The Committee recommends the following amendments:

"The title should be amended to read 'Wilbur J. Cohen, Acting Secretary of the Department of Health, Education and Welfare.

"The last 'Resolved' should be amended to read:

"RESOLVED, That its delegates to the American Medical Association be instructed to join the other great state associations in the adoption of a similar policy of opposition on the part of the American Medical Association to the confirmation of this appointment."

"The Committee recommends the adoption of the resolution as amended and further recommends that our delegates to the American Medical Association shall institute efforts aimed at persuading Congress to form a separate Department of Health headed by a qualified doctor of medicine with cabinet status."

Dr. Steward, President: "A point of information—Dr. H. Phillip Hampton was recommended by the Legislative Council of the American Medical Association to be a member of the medical advisory committee on Title XIX, which was created by the 90th Congress. All of you know Dr. Hampton is one of the most knowledgeable men in the country on this subject. He was

introduced in Washington as one of the advisory committee and then he was informed that he was totally unacceptable to Mr. Cohen. This is on a philosophical basis—I think it speaks highly for Phillip—but I thought you should know."

Dr. Sackett: "I would question the word 'Acting' because by the time this hits the AMA, he could be full 'Secretary'."

Dr. Cook thought this was splitting hairs, as he is Acting now.

Dr. Sackett: "I would move to add another Resolved: and further be it

"RESOLVED, That should the appointment of Wilbur J. Cohen have been confirmed at the time of the AMA meeting, by the full Senate, the AMA will publicly proclaim its displeasure with this appointee and his philosophies, along with an apprisal of individual members of the Congress of this fact with the reasons therefor."

Dr. Collin F. Baker Jr., Hillsborough, moved for division of the question between the resolution and the recommendations of the committee.

The Speaker agreed to this division.

Dr. Dewitt C. Daughtry, Dade: "I think this again is the way we got into difficulty last year. I don't think this is the way to do it. What we should do is write our Congressmen. All we do here is to embarrass ourselves and embarrass the American Medical Association.

Dr. James R. Jude, Dade: "I am also strongly against this resolution. We might as well vote against the war in Vietnam. It is a good way to give us a black eye as physicians. Let's be positive and for something. Let's go to our Senators and prevent confirmation of this appointment. This is the democratic way of doing it. If they don't do it, let's vote against them next fall."

Dr. Sackett appealed for passage of this resolution on the grounds that the rules and regulations of Medicare and Medicaid would be coming down to the state level and he would be asked his opinion as a doctor. He would like to be able to say to the House of Representatives that the Florida Medical Association and the American Medical Association do not approve. Also, he pointed out that if organized medicine does not voice its displeasure, this man might be reappointed after the election if the Democratic party wins. If it does not, then medicine will be in the good position of having shown its displeasure.

Dr. Hampton: "As a Wilbur Cohen reject, I am opposed to the motion. I think we will just be spinning our wheels and not accomplishing our purpose. Mr. Cohen is a realist, and while we disagree, I believe he is intellectually honest. If we just pass a resolution, we are not accomplishing anything. Let's organize our efforts to work as efficiently and effectively as Mr. Cohen does to promote his concepts."

Dr. Jesse W. Castleberry, Orange: "I believe it is the responsibility of doctors of medicine as well as all citizens, when we know something is wrong to speak out. We know this is wrong. Several other great states have taken this position along with us. Two other states last year submitted resolutions to the American Medical Association to try to have this man removed, and it is likely if the AMA had taken a stand he would not be Acting Secretary. I believe this is the way to make our voice heard—not as individuals."

Dr. Evans did not agree with Dr. Sackett and thought probably the reason Dr. Hampton was rejected was because we had passed a similar resolution last year. He was, however, in favor of the recommendation to persuade Congress to form a separate Department of Health headed by a qualified doctor of medicine with cabinet status.

Dr. William H. Keeler Jr., Pinellas: "I would like to endorse Dr. Sackett's motion for adoption by this House. It sickens me to hear someone say we are going to incur another black eye. I think we should stand up for what we believe and act on our convictions, rather than backing away from a fight. I think this resolution should be adopted, and also agree with Dr. Evans that the second part of this resolution should be included and endorsed."

Dr. Carl N. Reilly, Charlotte: "As one of the original authors of this project last year, I agree with Dr. Hampton—Mr. Cohen is a realist and he expects you to do just exactly what you are proposing—to forget about it and be gentlemen. I disagree that he is intellectually honest—he is not. He promised us that he wanted Medicare only. He has already told the press that he wants all of medicine socialized."

The Speaker called for a vote on Dr. Sackett's amendment, which was the last amendment.

Motion carried.

The Speaker called for a vote on the last amendment to the resolution in the committee report.

Motion carried.

Dr. Cook asked for a vote on the amendment to delete the third 'whereas' of this resolution.

Motion carried.

The Speaker requested a vote on the amendment to the title.

Motion carried.

Motion carried to adopt the resolution as a whole as amended.

Dr. Caroline B. Hunter, Dade, rose to a point of order and said she was not sure the House understood what they had voted for and requested a re-vote on the whole resolution as amended.

Motion carried.

The Speaker now called for a vote on the recommendation to request a separate Department of Health with a qualified doctor of medicine at its head with cabinet status.

Motion carried.

Resolution 68-23

Wilbur J. Cohen, Acting Secretary of the Department of Health, Education and Welfare
Walter W. Sackett Jr., M.D., Delegate

Whereas, Wilbur Cohen, a long avowed opponent to the philosophy of the accepted concepts of the private practice of medicine has been appointed to the cabinet post of Secretary of Health, Education and Welfare; and

Whereas, This appointment has not to this date been confirmed by the United States Senate: Therefore, be it

RESOLVED, That this House of Delegates of the Florida Medical Association voice its approval of a policy of active opposition to the confirmation of Wilbur Cohen's appointment; and further, be it

RESOLVED, That its delegates to the American Medical Association be instructed to join the other great state associations in the adoption of a similar policy of opposition on the part of the American Medical Association to the confirmation of this appointment; and further, be it

RESOLVED, That should the appointment of Wilbur J. Cohen have been confirmed at the time of the AMA meeting, by the full Senate, the AMA will publicly proclaim its displeasure with this appointee and his philosophies, along with an apprisal of individual members of the Congress of this fact with the reasons therefor.

Dr. Zivitz said that this completed his report. He thanked the members of his committee and the members of the Association who contributed so much to the discussion.

The Vice Speaker took the Chair.

Dr. James M. Walker, Chairman, Committee on Nursing, announced that the First Florida Medical Association—Florida Nurses Association Conference would be held on Friday and Saturday, June 7 and 8, at the Robert Meyer Motor Inn in Orlando. "The title, 'New Horizons in Nurse-Physician Relations,' should be very interesting and very challenging to all those who participate. This conference will be patterned after three national conferences which have been held in various sections of the country and we will be the fifth state medical association to sponsor such a conference. This is an invitational meeting and each county medical society and each district of the nurses association will be asked to send one or more delegates. The county societies should pick men who are interested in nursing liaison and who can contribute the most to this conference. The hotel expenses will be paid for both physicians and nurses by a generous grant from Merck Sharp & Dohme."

Report of Reference Committee No. III
Finance and Administration

Dr. William C. Roberts, Chairman: "The Reference Committee's recommendation on each item will be submitted separately and I respectfully suggest that each item be acted upon before going to the next.

"The Reference Committee considered the report of the Board of Governors and recommends acceptance of those portions of the report referred to Reference Committee No. III."

Dr. Jude, Dade, asked if this included item 24 on page 36 which dealt with the current membership of Medical Districts.

Dr. Donegan replied that this did include item 24.

Dr. Jude thought that because of the difference in population of physicians between District A and District D, perhaps some redistricting is necessary. He moved that a redistricting take place so that there would be a one physician-one vote type of rule.

Dr. Steward explained that to alter District "D" would mean it would be necessary to split Dade County.

Dr. Jude: "It is obvious that this is likely to increase in disparity and I would move that a committee be formed to revise the By-Laws so that proper vote can take place."

Motion was seconded.

Dr. Ralph Jack, Past President, asked if this would cause a change in AMA by-laws, since the unit is a county society.

Dr. Zellner, Past President: "This has nothing to do with the vote. One man-one vote is not germaine to this question. What it simply means is that committee appointments are divided by district. One man may very well represent a wide area, but there is no vote involved. We do have proper representation in this House of Delegates—one man for each 25 members except in those county societies which have less than 25 members. If it is the desire to increase the number of districts, which would increase the number of members of committees, that might be done, but I don't think we should suggest that any one area is over-represented, except on committees which actually have no vote in this House."

Motion lost.

Motion was carried to approve the recommendation of the Reference Committee.

Please note that portions of this report were considered by Reference Committees other than No. III, as indicated.

Report of the Board of Governors

W. DEAN STEWARD, *Chairman*

The Board held four meetings during the Association's administrative year. They were held on May 14 and September 28-29, 1967, and January 14 and March 30, 1968. The Executive Committee of the Board held six meetings during the year.



Composing Reference Committee III were Drs. W. C. Roberts, chm., W. A. Van Nortwick, W. M. Myers, R. B. Carson and R. C. Clay.

The Chairman would like to express his appreciation to the officers, the members of the Board of Governors, the Council and Committee Chairmen, and the many individual members of the Association for their interest, activities and accomplishments during this year. Particular appreciation is expressed to Thad Moseley, M.D., retiring Editor of The Journal, his Assistant Editors, and to Mason Romaine, M.D., retiring Chairman of the Association's Council on Voluntary Health Agencies since its inception. It has been a great personal pleasure and satisfaction to have the opportunity to be closely associated with so many fine physicians who make our Association one of the most outstanding in the nation.

Major Activities

Annual Meeting—The Board of Governors approved the format for the 1968 annual meeting and the scientific program as submitted by the Committee on Scientific Assemblies. The Board observed that a total of 2,280, of which 1,264 were physicians, attended the 1967 annual meeting.

Presidents' and Secretaries' Conference.—The Tenth Annual Conference of Presidents and Secretaries of County Medical Societies was held in January 1968 in Orlando. Again this year, the purpose of the conference was to orient the officers of the county medical societies regarding major programs and activities of the Association, to better facilitate their programming and implementation at the county level. The Conference was received enthusiastically by the county society representatives, and over 90% of the membership was represented by their respective county society officers.

Financial Statement and Budget—The Board reviewed the Financial Statement prepared by the Secretary-Treasurer and the Executive Director, and the auditor's statement prepared by the Association's certified public accountant for the Association's fiscal year, which was the calendar year 1967. The Association had an income from all sources of $361,994; total expenses incurred were $299,617, for a gross excess of income over expenses of $62,377. The Board approved an annual operating budget for the calendar year 1968 in the amount of $346,000, which included $20,000 for reserve and property amortization. In compliance with the By-Laws, this budget was prepared by the Executive Director after consultation with the Secretary-Treasurer, reviewed by the Executive Committee, and approved by the Board of Governors. It was based upon an anticipated income of $346,000. Copies of the CPA audit are on file at the Association's office and available for review by the members of the Association.

Appointments—On May 14, 1967, the Board of Governors appointed Burns A. Dobbins Jr., M.D., as the AMA Delegate to serve on the Board of Governors; Eugene G. Peek Jr., M.D., as the State Board of Health representative on the Board of Governors; approved appointment of William J. Dean, M.D., as the optional member of the Executive Committee; George S. Palmer, M.D., as Public Relations Officer; reappointed Thad Moseley, M.D., as Editor and accepted the Editor's nominations of John M. Packard, M.D., and Oscar W. Freeman, M.D., as Assistant Editors; reappointed Jack Q. Cleveland, M.D., as the Assistant Editor from the Board of Governors; reappointed the Committee on Research members with Karl B. Hanson, M.D., as chairman; reappointed the Subcommittees on Inter-American Relations, Quackery, and Venomous Snake Bite. The Board appointed a special committee to implement the intent of Resolution 67-20, Individual Responsibility Policy, composed of Irving E. Hall Jr., M.D., chairman; Jack A. MaCris, M.D.; Jesse W. Castleberry, M.D.; Carl N. Reilly, M.D., and Harold A. Yount, M.D. It also appointed a special committee on Resolution 67-22, Blue Cross and Blue Shield, composed of the FMA President, FMA Past Presidents serving on the Blue Cross and Blue Shield Boards of Directors, the chairman of the Association's Council on Medical Economics, and the chairman of the Committee on Advisory to Blue Shield, with Robert E. Zellner, M.D., serving as chairman.

Recognition—The Board reviewed the nominations received from county medical societies and selected the recipient for the A. H. Robins Company Award "For Outstanding Community Service by a Physician" to be presented at the first meeting of the House of Delegates, May 9, 1968 (Award nomination will be included in the delegates' packets).

The Board resolved that a certificate of grateful recognition be presented to Harry T. Gray, Association's legal counsel for 43 years, as a small token of the warm appreciation that the officers, members and the executive staff of the Association hold for the many years of outstanding legal services rendered by this grand gentleman and scholar.

Referrals by House of Delegates

The Board reviewed the following resolutions:

Substitute Resolution 67-3 & 8, Wilbur J. Cohen—This resolution was submitted by the Florida Delegation to the AMA House of Delegates in June 1967 as AMA Resolution No. 99, and the Reference Committee report adopted by the House of Delegates of the AMA considerably changed the Florida resolution. Your Board of Governors advised Florida's entire congressional delegation of the content of the FMA substitute resolution. (R. C. IV accepted as information.)

Resolution 67-17, State Fair Exhibit—Your Board considered the content of this resolution and determined that the Florida Medical Association should not exhibit at the Florida State Fair but that medical exhibits at county fairs be continued by the respective county medical societies.

Resolution 67-20, Individual Responsibility Policy—A special committee was appointed for implementation of this resolution. The program and information for distribution were approved at the January 1968 meeting of the Board of Governors and transmitted to each member of the Association in a special informational packet. (R. C. V approved.)

Resolution 67-22, Blue Cross and Blue Shield—The subject of this resolution was referred to a special committee appointed by the President. The Board of Governors reviewed and approved the report as submitted and received a minority report from one member of the committee as information. The entire report appears on pages 1078 and 1080 of the Journal FMA, November 1967. (R.C. V approved.)

Other resolutions adopted by the House were referred to the appropriate committees for action. Individual actions will be reported in the respective Council reports.

Special Report—The Board of Governors received and reviewed three special reports concerning Comprehensive Health Planning, the Governor's Steering Committee on Health, and the Regional Medical Program in Florida. Due to their importance and in an effort to advise the House of their status, the reports are presented in their entirety as follows:

Comprehensive Health Planning—P.L. 89-749; Partnership for Health Amendments of 1967—P.L. 90-174—The Honorable Claude Kirk, Governor of the State of Florida, has designated his office as a single state agency for Comprehensive Health Planning. This will be the sole agency for coordination and supervision of the comprehensive health planning functions which are to be carried out under the plan. By Florida Statute, the Governor is the chief planning officer of the State of Florida as provided for in the Florida State Planning Law. Mr. Robert W. Roesch has been designated comprehensive health planning director by the Governor.

The Florida Health Planning Advisory Council to the State Agency has been appointed by Governor Kirk, and its first meeting was held March 23, 1968. The Federal Statutes provide that a majority of the Advisory Council

be consumers. This 52-man Council has among its membership 10 members of the Florida Medical Association—five are in the private practice of medicine, three are representatives of Florida's medical schools, and two represent state agencies.

A planning grant application has been submitted and approved by the federal government and independent consultants have been retained from Washington, D. C., to do a study of the current planning and coordination for health purposes in the state of Florida.

Samuel M. Day, M.D. is currently serving as chairman. (R.C. IV approved.)

Governor's Steering Committee on Health—Governor Kirk on May 12, 1967, at the Florida Medical Association annual meeting, issued an executive order establishing a Steering Committee on Health. This committee is composed of 14 members, 10 of whom are members of the Florida Medical Association.

The organizational meeting was held July 9, 1967. Two subcommittees were appointed to carry out specific reviews requested by Governor Kirk: one to study the cost and number of medical students at the University of Florida, and the other on drug purchasing practices by state agencies. These committees completed their preliminary studies and reported to the full committee on March 23, 1968.

Other subjects designated in the executive order will be studied at the earliest practical date.

Samuel M. Day, M.D. is currently serving as chairman.

Education, Research, Training and Demonstrations in the Field of Heart Disease, Cancer, Stroke and Related Diseases—P.L. 89-239—The Florida Medical Association participated with other organizations at a meeting on December 12, 1965. As a result of this meeting, the Florida Advisory Council on Heart Disease, Cancer and Stroke, Inc., a corporation not for profit, was formed and approved by the Secretary of State's office on May 20, 1966.

This corporation's directors are composed of four members of the Florida Medical Association; the State Health Office; representatives of Florida's three medical schools; Florida Hospital Association; Florida Heart Association; Florida Division, American Cancer Society; a member of the Board of Trustees of the University of Miami; a member of the Board of Regents of the State of Florida, and a member of the public (who is also a member of the Board of Regents.)

An Advisory Group as required by law (in addition to the Board of Directors) has been established, with representatives of related health organizations, consumers and minorities.

A planning grant application was submitted on June 8, 1967, in the amount of $639,753 for the first 12 month period. The planning grant application was disapproved; one of the reasons given was that the corporation had no assets for audit exceptions.

The Florida Medical Association and the Florida Medical Foundation agreed to assume responsibility for an amount not to exceed $100,000 for audit exceptions or any claimed misuse of funds granted to FAC, Inc. A revised planning grant application was submitted, and on January 12, 1968, the National Institutes of Health approved a grant in the amount of $200,000 for direct costs and $40,000 for indirect costs, to be negotiated. The grant period is from November 1, 1967, to October 31, 1968.

H. Phillip Hampton, M.D., is serving as State Chairman; Samuel P. Martin, M.D., is Acting Program Coordinator. The Florida Medical Foundation is serving as the fiscal agent. To date, three applicants have been interviewed for the position of Program Director. The program provides for three area coordinators, and Lamar Crevasse, M.D., University of Florida College of Medicine, has been retained as the Northeast Florida coordinator, on a 75% time basis. The area coordinators for the South and Central West Coasts areas are vacant and individuals are being considered for these positions. (R.C. I approved.)

Nominations

Certificate of Appreciation—Your Board recommends that Wilson T. Sowder, M.D., of Jacksonville, be awarded the Association's Certificate of Appreciation (Complete nomination will be included in the delegates' packets).

Committee on Membership and Discipline—As provided for in the By-Laws, the Board of Governors nominates the following physicians for those terms expiring in 1968 and for vacancies created by reapportionment of congressional districts:

District 2:
- Alfred L. Lewis Jr., M.D., Tallahassee 1972
- J. Maxey Dell Jr., M.D., Gainesville 1970

District 4:
- Karl T. Humes, M.D., Bushnell 1972

District 6:
- Ernest R. Bourkard, M.D., Tampa 1972

District 8:
- Rowland E. Wood, M.D., St. Petersburg 1972

District 11:
- Nelson Zivitz, M.D., Miami Beach 1972

District 12:
- Rufus K. Broadaway, M.D., Miami 1972

Blue Shield Board of Directors—The Board of Governors reviewed the nominations for the Blue Shield Board of Directors presented by the Blue Shield Nominating Committee and from the nominations for each physician directorship the following were chosen:

Medical District A:
- Henry J. Babers Jr., M.D., Gainesville
- I. Barnett Harrison, M.D., Tallahassee

Medical District C:
- Myrl Spivey, M.D., West Palm Beach
- Michael R. Blais, M.D., Daytona Beach

Medical District D:
- John D. Milton, M.D., Coral Gables
- Richard C. Dever, M.D., Miami

At Large:
- Robert E. Zellner, M.D., Orlando
- William M. C. Wilhoit, M.D., Pensacola

The lay members nominated by the Nominating Committee were approved by the Board as follows:

Medical District B:
- William Roy, Orlando

At Large:
- H. P. Osborne Jr., Jacksonville

(R.C. V approved.)

Board Actions of Importance

1. AMA Board of Trustees—Successfully supported the election of Edward R. Annis, M.D., to the Board of Trustees of the AMA to fill the unexpired term of the late Homer L. Pearson Jr., M.D.

2. FMA Relative Value Studies—Approved the Association's Committee on Relative Value Studies updating the 1964 California Relative Value to be adopted as the Relative Value Studies of the FMA. The 1968 Relative Value Studies have been mailed to each member of the Association. (R.C. V approved.)

3. Medicare—Requested and received with thanks an excellent report from Warren W. Quillian, M.D., President of Blue Shield of Florida, on the current status of Blue Shield serving as Title XVIII-B carrier, the policy for determining fees, and other information. (R.C. V accepted as information.)

4. Directory—Authorized the continued use of IBM in compiling the Florida Medical Directory, including in Roster 1 of county medical societies the physicians' specialties, and an alphabetical Roster 2 including all members of the Association.

5. Future Meeting Dates—Reconfirmed and approved the following dates and locations for the annual meetings, subject to satisfactory facilities and arrangements:

May 14-18, 1969 ..... Americana Hotel, Bal Harbour
May 6-10, 1970 ..... Diplomat Hotel, Hollywood
May 5-9, 1971 ..... Americana Hotel, Bal Harbour
May 3-7, 1972 ..... Diplomat Hotel, Hollywood
May 9-13, 1973 ..... Americana Hotel, Bal Harbour
May 8-12, 1974 ..... Diplomat Hotel, Hollywood

Tentative dates on a first refusal basis have also been made in May 1971 at the Diplomat Hotel, in the event the facilities and arrangements are not satisfactory at the 1969 meeting at the Americana Hotel (The 1967 FMA House of Delegates left the dates and locations of the annual meeting to the discretion of the Board of Governors).

6. Specialty Societies—Granted recognition to the Florida Gastroenterologic Society and to the Florida Society of Thoracic Surgeons.

Removed the probationary status of the Florida Psychiatric Society. (R.C. I approved.)

7. Blue Shield Claims Committee—Blue Shield, at the request of the Association, enlarged its claims Committee to have representatives in other geographic areas of the state of Florida rather than just in Jacksonville. (R.C. V approved.)

8. Workmen's Compensation—The Board was advised that at the request of the Chairman of the Florida Industrial Commission the Florida Medical Association's President nominated physicians to serve on the Advisory Committee to the Florida Industrial Commission for revision of the fee schedule and other necessary matters regarding the program. A confidential progress report of the chairman of this ad hoc committee was reviewed by the Board of Governors and received as information, and the chairman was asked to continue to work with the Industrial Commission for usual and customary fees. The Board reaffirmed its action of September 1966 which reads as follows: "That an FMA Committee designated by the President discuss and advise the indicated changes in the billing procedures, the Relative Value Studies, and the conversion factors regarding care of Workmen's Compensation patients and that the Florida Medical Association be prepared to take necessary legal action to test the validity of the Florida Industrial Commission's interpretation of the Florida Workmen's Compensation statutes in its refusal to pay the usual and customary fees charged by doctors of medicine of Florida for the care of patients with industrial injuries," and suggested that the physicians of Florida use the principles of the Individual Responsibility Program, presenting their bills for Workmen's Compensation services directly to the responsible person. (R.C. V approved—see page 669 for additional recommendations of R.C.)

9. Medicare—Part B—Hearing Officer. (R.C. V disapproved.)

10. Ambulance Service — The Governor's Steering Committee on Health was requested, in cooperation with the Association's Committee on Emergency Medical Service, to review the matter of ambulance service in rural areas and make an early study to determine the feasibility of statewide ambulance service in the most efficient and modern manner. (R.C. II, approved.)

11. Professional Liability—The Broad reviewed the subject of some hospitals requiring mandatory limits of professional liability coverage for staff privileges, and received a legal opinion from the Association's attorney that in his opinion a hospital may make such a requirement as long as it is reasonable. (R.C. V, received as information.)

12. Extended Care Facilities—Requested clarification of the federal government's position on custodial versus extended care, and clarification as to whether this decision should be a professional one or determined by lay persons. (R. C. V approved.)

13. FLAMPAC—Approved the District Chairmen of the Florida Medical Political Action Committee as recommended by its Chairman, and reaffirmed the aims and purposes of AMPAC and FLAMPAC, and urged support for these organizations in the interest of continuance of the free practice of medicine in the state. (R.C. IV approved—see page 663 for additional recommendations of R.C.)

14. FMA Investment Plan—Reviewed the progress and growth of the FMA Investment Plan and approved amendments to the rules and regulations governing it.

15. Postgraduate Education—Authorized a grant application to be submitted to Mrs. Jessie Ball DuPont and to various foundations, if necessary, to implement a postgraduate medical education program, utilizing closed circuit television and video tape presentations. (R.C. I approved.)

16. Board of Examiners in the Basic Sciences and Florida State Board of Medical Examiners.—The Board of Governors approved the amendments to the Medical Practice Act and retention of the Board of Examiners in the Basic Sciences as recommended by the Judicial Council.

17. Tax Exemptions—The Board authorized application to the Internal Revenue Service, U. S. Treasury Department, for a blanket tax exemption for all component county medical societies.

18. Blue Cross of Florida, Inc.—Your Board received an opinion that Blue Cross of Florida, Inc., was violating its charter and the Florida Statutes by payment of physicians' fees when its charter restricts it to hospital services. Your Board authorized the Florida Medical Association to enter a suit in the courts against Blue Cross of Florida, Inc., for violation of its charter. A conference was held with representatives of Blue Cross and Blue Shield, the Association and the Association's legal counsel. The Board accepted the recommendations of the Executive Committee that after review by legal counsel there are no grounds for suit against Blue Cross for violation of its charter, but there is a possibility that Blue Cross is violating the Medical Practice Act by payment to hospitals for physicians' services. (R.C. V received for information.)

19. Governor's Appointments—The Board of Governors was advised that Governor Kirk had followed the recommendations of the Association for appointments to the State Board of Medical Examiners and reappointed J. Champneys Taylor Jr., M.D., appointed John J. Cheleden, M.D., Vernon B. Astler, M.D., and Scheffel H. Wright, M.D. One appointment was made without consulting the Association.

20. Lawsuit—Your Board was advised of a lawsuit in Dade County regarding telephone listings of physicians in the area and authorized the Association to intervene as a party to the suit with the Dade County Medical Association. At the time of this report the case is on appeal.

21. Determination of Fees—Your Board approved the recommendation of the Committee on Advisory to Blue Shield and the Committee on Health Insurance that in determining usual, customary and reasonable fees, localities not smaller than county size be considered, and that in a case where the Blue Shield Claims Committee considers a billed fee excessive, and the case is referred to the insurance review committee in the area involved; if the recommendation of the local insurance review committee is not acceptable to Blue Shield Claims Committee, the latter committee shall seek advice from the Health Insurance Council of the Florida Medical Association before making a final decision. (R.C. V approved as amended.)

22. Interama—Requested the Board of Trustees of the AMA to consider participation in Interama at Miami, Florida.

23. Disneyworld—The Board was informed of correspondence with Walt Disney Productions in which the

facilities of the Association were offered in planning medical services for their cities and their reply that they would confer with the Association's President.

24. Medical Districts—The Board was advised that the current membership of the Association by Medical District is as follows:

District A — 1,162
District B — 1,462
District C — 1,591
District D — 1,665

Based upon this distribution, no redistricting was deemed necessary.

25. Nursing—The Board approved the recommendation of the Committee on Nursing that efforts be made to enlarge classes in the present baccalaureate nursing programs in Florida; to preserve the remaining diploma (two and three year) schools of nursing and to reestablish others; that an extra year of in-hospital on-the-job training for all graduate nurses be encouraged; that all programs for nurse training stress more clinical and bedside nursing, and that the FMA go on record as reaffirming the nurse as a member of the professional health team, deserving the respect and help of all FMA members and deserving a salary commensurate with knowledge and experience. (R.C. II approved as amended.)

26. Specialty Medicine—Disapproved two recommendations of the Council on Specialty Medicine—one regarded a By-Laws change placing the chairman of the Council on Specialty Medicine on the Board of Governors, and the other dealt with the location of the Board meetings. (R.C. I approved—see page 629 for additional recommendations.)

27. Medical Education: Statement of Policy—The Board of Governors adopted the following statement of policy regarding medical education in Florida:

> The Florida Medical Association has been considering the trends in medical education, particularly in our state and we would like to share some of our thoughts with you.
>
> Throughout the country, medical schools in recent years have become increasingly involved in medical research so that now over 50% of the income of medical schools is derived from research grants. This has caused some restriction in the time of medical educators available to teaching both in medical schools and in continuing medical education. It has also tended to concentrate medical school activities within their own confines rather than extend them into the medical community and may have diminished their productive effort in the field of education.
>
> On the other hand, many medical schools have developed rather elaborate and prestigious outpatient clinics and hospitals as educational facilities and as means of attracting a better faculty. Perhaps some thought should be given to improving the educational value of medical school clinics and hospitals for both the medical student and practicing physician.
>
> The medical student's education provides him with the basic information to enable him to acquire medical knowledge, skills and pattern of behavior in his internship and residency in teaching hospitals. The educational activities of teaching hospitals too often are dependent on chance voluntary effort of practicing physicians and closer relationships should be developed between medical schools and community teaching hospitals.
>
> These are some of the concerns we feel should be given consideration in the development of the new medical school at the University of South Florida in Tampa and expansion of the existing medical school at the University of Florida in Gainesville. In short, there should be greater participation of the practicing medical profession in medical schools, greater participation of medical schools in continuing medical education and closer interrelationship between medical schools and adjacent community teaching hospitals. (R.C. I approved.)



Friday morning's scientific session was a symposium on "The Use and Abuse of Antibiotics and the Future of New Therapeutics."

28. Journal Editor—Determined that in the future, the term of office of the editorship of The Journal of the Florida Medical Association shall be limited to a maximum of five annual appointments for any one individual.

29. Executive Director—Renewed for a period of five years the five-year renewable contract of employment dated January 12, 1964, with W. Harold Parham, Executive Director.

Recommendations:

BY-LAWS—After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association, Inc.:

1. Chapter IV, Section 15, add a new Section 5, to read as follows:

"5. Reference Committee attendance at any meeting shall be restricted to members of the Florida Medical Association, other doctors of medicine who are guests of the Association, members of the Association staff required to assist the committee, and only such other individuals who shall be invited by officers of the Association or the Reference Committee itself."

(This implements the policy adopted by the House of Delegates in 1963.)

2. Chapter VI, Section 5. *Secretary*, third paragraph shall be amended to read as follows:

"He shall maintain a roster of all *members of the Florida Medical Association,* noting their status with respect to the relevant component society and the Association. He shall submit to the American Medical Association such reports as required regarding *members of the Association.* His office and services shall be available to the officers of the Association, the members of the Board of Governors, Committee and Council Chairmen, and county society officials.

"He shall direct official correspondence, notifying members of meetings, and disseminating

other notices and announcements as required. All the facilities and personnel of the Executive Office shall be at his disposal."

(This removes the requirement for the Secretary-Treasurer to maintain rosters of licensed doctors of medicine regardless of their status with the Association. This is a function of the Florida State Board of Medical Examiners. It further removes the requirement for the Secretary to submit a written report to the Board of Governors and it being published in the Journal. This report would a duplication of the annual report of the Board of Governors.)

3. Chapter IX, Section 1, Paragraph 2, shall be amended to read as follows:

"The Council on Allied Professions and Vocations: Committees on Dentistry, Law, Medical Assistants, Medical Technologists, Nursing, Pharmacy, Physical Therapy, *and Rehabilitation Therapists*, Religion, Veterinary Medicine, Radiological and Nuclear Medicine Technologists, *and other paramedical personnel as approved by the Board of Governors.*"

(This adds "and Rehabilitation Therapists" to the Committee on Physical Therapy, and provision for other paramedical personnel as approved by the Board of Governors.)

4. Chapter IX, Section 2, paragraph 4, Medical Schools—This Committee shall be composed of eight members appointed by the President of the Association, who shall select one member from the medical faculty of the University of Miami School of Medicine, one member from the medical faculty of the College of Medicine of the University of Florida and *one member from the faculty of the college of medicine of the University of South Florida;* one member of the Dade County Medical Association, one member of the Alachua County Medical Society, one member of the Hillsborough County Medical Association, one member from Medical District "C" (not having an approved medical school within its boundaries) of the Florida Medical Association, and one member from the Florida Medical Association at large. These appointments shall be for four years except that the initial terms shall be staggered to provide for a minimum change of members in any one year.

The Speaker asked Dr. Leo M. Wachtel and Dr. Samuel M. Day to escort Dr. Wilson T. Sowder to the podium.

Dr. Donegan: "In this report of the Board of Governors, was the recommendation to present to Dr. Wilson T. Sowder, the Association's Certificate of Appreciation."

Dr. Donegan read the Certificate.

Dr. Sowder: "When I learned that certain allegations were to be made, I attempted to get the particulars, but all I could get was a glance. I had intended to deny the whole thing.

"I am deeply grateful to the members of the House of Delegates and to the membership of the Florida Medical Association. This is a tremendous honor and I will always be proud of it. Thank you."



Dr. Wilson T. Sowder, state health officer, addresses the House after receiving the Certificate of Appreciation.

Certificate of Appreciation

WHEREAS, Wilson Thomas Sowder, M.D., of Jacksonville, a respected member of the Florida Medical Association serving as State Health Officer for more than two decades, has made an invaluable contribution to the health and well-being of the people of Florida, the United States and other nations, and merits special recognition for his achievements, and

WHEREAS, This distinguished physician, born at Callaway, Virginia, in 1910, attended local schools; received his premedical education at the University of Virginia and the degree of Doctor of Medicine from that University's School of Medicine in 1932; completed an internship at University of Iowa Hospitals, Iowa City, and a residency at St. Luke's Hospital, San Francisco, and was awarded the degree of Master of Public Health by Johns Hopkins University in 1939, and

WHEREAS, This young physician entering the U. S. Public Health Service in 1934 served four years in U. S. Marine Hospitals in Baltimore and Seattle; with the U. S. Coast Guard in Alaska; at the U. S. Quarantine Station in San Francisco, and as director of the Venereal Disease Control Program of the Tennessee Department of Health, and

WHEREAS, This practitioner of preventive medicine came to Florida in 1940 on assignment by the Secretary of the Navy to serve as venereal disease control officer at Pensacola and later at Tampa; became health officer of Hillsborough County; later director of the Division of Venereal Disease Control, then director of the Bureau of Local Health Services and Assistant State Health Officer, Florida State Board of Health, and

WHEREAS, This noted physician became a consultant in communicable disease control for the War Shipping Administration in Washington, D. C., in 1944 and the following year consultant in general public health and venereal disease control for the U. S. Public Health Service in Dallas, Texas, and

WHEREAS, In September, 1945, this prominent leader was granted leave of absence from the U. S. Public Health Service to become health officer of Florida—at age 35 one of the youngest in the nation; eleven years

(Continued on page 649)



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101


burning
itching
discharge
of trichomonal vaginitis...

Flagyl®

tablets/inserts

brand of

metronidazole

brings

- clinical cures
- microscopic cures
- culture cures

For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

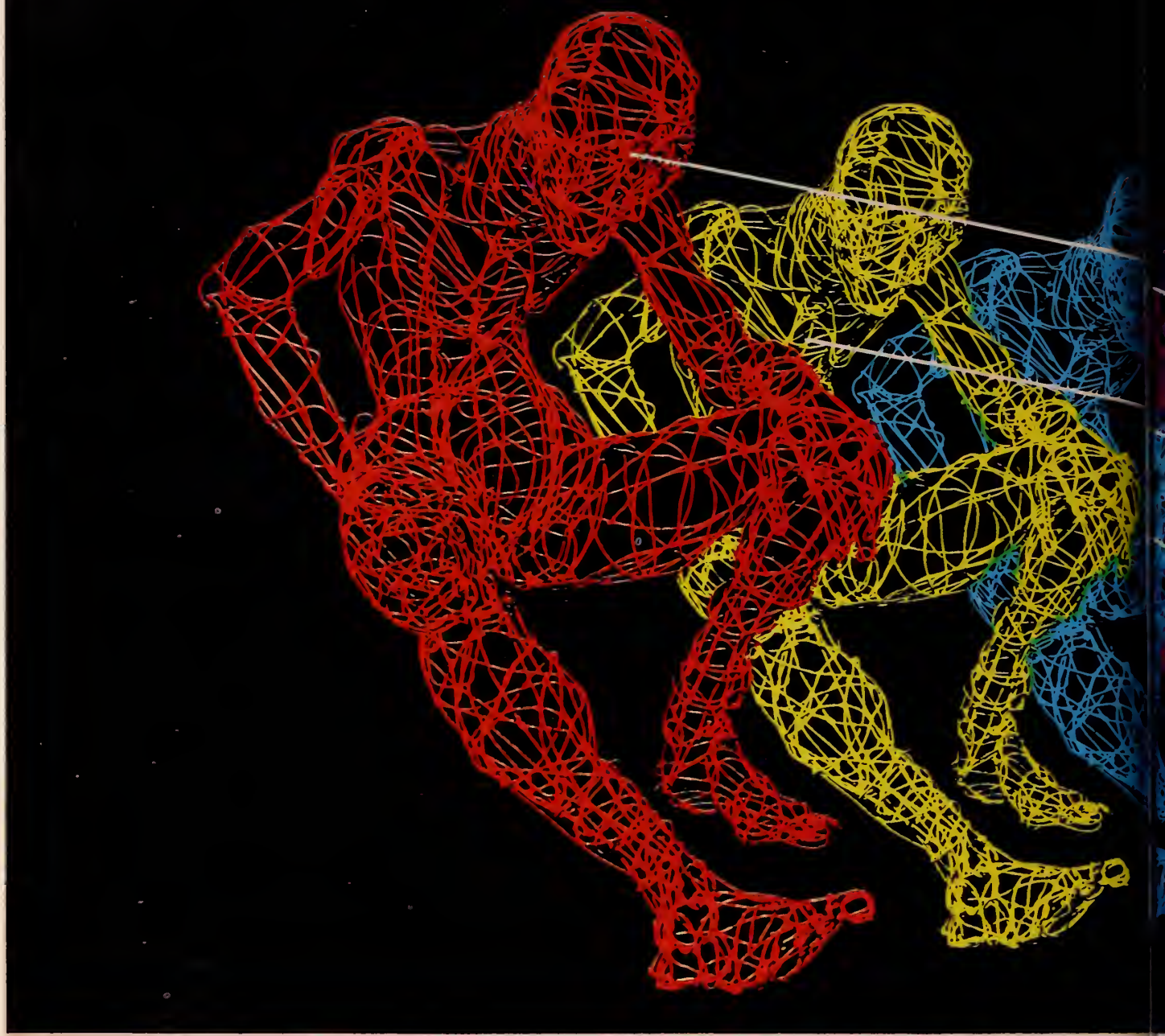
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

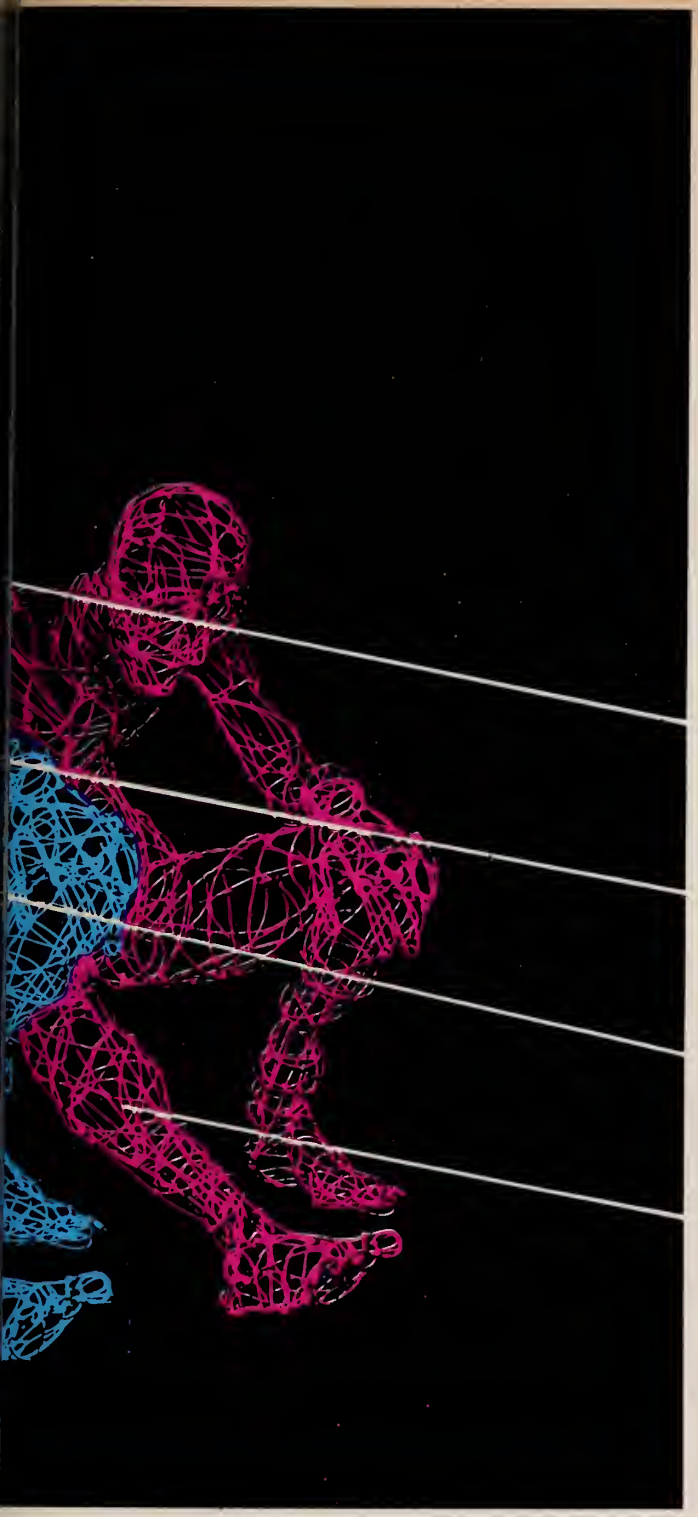
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral, or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mc B_{12} activity)—helps provide adequa levels of this important vitamin.

Folic acid (1 mg.)—treats nutritior macrocytic anemias and/or malabsor tion syndromes.

Ascorbic acid (75 mg.)—augments t conversion of folic acid to its active fo and helps iron absorption.

Iron (110 mg.)—treats hypochron anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
801668

Lilly



Are your patients confused by ad claims?
by shapes and sizes? by strange-
sounding ingredients?
When they need fast
relief from pain, you
can reassure them that
aspirin is still the
strongest analgesic they
can buy without your
prescription. And
Bayer is 100% aspirin.
No wonder Bayer works wonders.

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

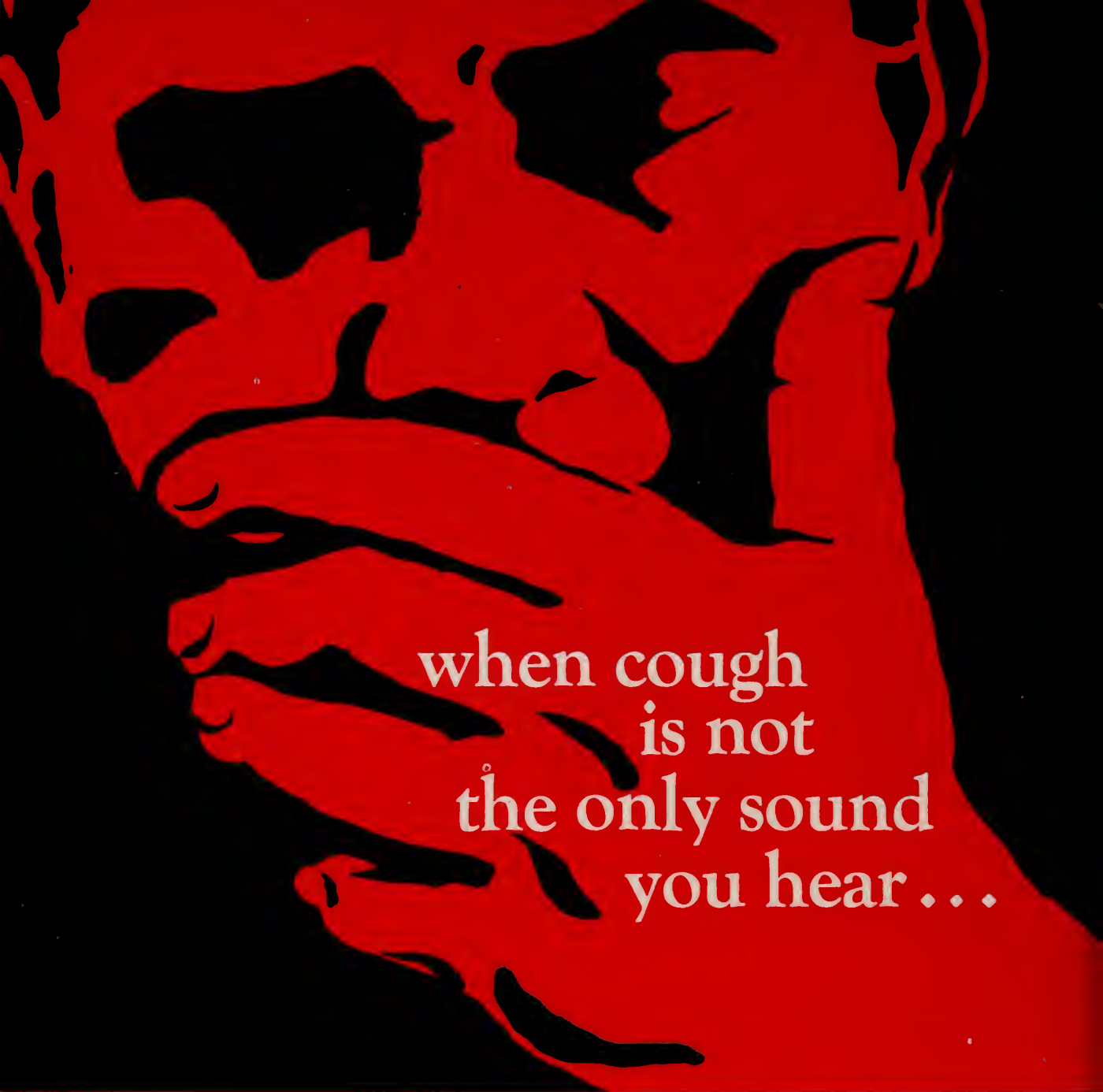
Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

later relinquished his USPHS commission indicating personal satisfaction in the location he had chosen for the practice of his professional special interest, and

WHEREAS, This respected physician, seeking further improvement in public health for his adopted state, actively supported and encouraged establishment of health departments in 31 counties; instituted programs of air and water pollution control, radiation surveillance, statewide mosquito control, chronic diseases, hospitalization for the indigent, mental health; emphasized research and the importance of laboratory facilities in public health activities; was instrumental in establishing the medical and dental scholarship program and, upon request of the U. S. Surgeon General in 1961, was granted a leave of absence from his duties as State Health Officer to set up the Office of Aging in the U. S. Public Health Service, and

WHEREAS, This internationally known physician, utilizing his knowledge and experience to benefit people in other countries, served as consultant to the U. S. Foreign Operations Administration in Colombia, Panama and Ecuador in 1954, as adviser to the United States Delegation to the 13th World Health Assembly in Geneva in 1960 by appointment of President Dwight D. Eisenhower, and as consultant to the government of Ecuador in establishing a Ministry of Health under auspices of the U. S. Department of State in 1963, and

WHEREAS, This outstanding health officer has served his profession as president of the American Association of Public Health Physicians, Association of State and Territorial Health Officers and the Florida Public Health Association; chairman, Section of Preventive Medicine, consultant, Council on Medical Services and Committee on Medical Facilities, American Medical Association; chairman, Executive Board, American Public Health Association; member, Advisory Board on Chronic Diseases of U. S. Public Health Service, White House Conference on Aging, President's Council on Youth Fitness; representative of American Medical Association on Board of Directors, National Council for Accreditation of Nursing Homes; Associate Editor, The Journal of the Florida Medical Association; Visiting Professor of Preventive Medicine, University of Miami School of Medicine and University of Florida College of Medicine, and diplomate of the American Board of Preventive Medicine and Public Health; therefore be it

RESOLVED, That the Certificate of Appreciation, established in 1961 for the purpose of acknowledging exceptionally meritorious service and awarded now for the third time, be presented to this devoted member of the Florida Medical Association in recognition of his many contributions to the people of this state and nation, and to the profession of medicine.

Dr. Roberts disgressed from his report to comment that Dr. Cheleden and his council had done a herculean job as the delegates could see from his report.

Dr. Roberts: "The Reference Committee considered the report of the **Judicial Council** and recommends the following amendments:

"That item No. 6 of the changes in the **Medical Practice Act** be amended by placing a period after the word 'Board' in the first line and deleting the remainder of the paragraph, so that it reads: '6. Retain the Basic Science Board.' "

Motion carried.

"That item 7 be amended by adding in the third line after the word 'examination,' the words 'except for lack of citizenship;' in the fourth line, adding after the word 'permanent' the words 'full time;' and at the end of the first sentence, add the phrase 'such license to be renewable not more than four consecutive one-year renewals on an annual basis.' "

Motion carried.

"That item 8 be deleted."

Dr. Scheffel Wright, Dade: "I make a substitute motion that this particular item in the report of the committee be rejected."

Motion was seconded.

Dr. Wright: "I am told that this is not politically expedient or practical to try to get all of the physicians employed by state institutions to have Florida licenses by January 1, 1972. This has been discussed by the State Board of Medical Examiners at great length, it has been discussed by the Judicial Council, by joint meetings with county societies and approved, and I feel this is an attempt by the Judicial Council and the State Board of Medical Examiners to improve the practice of medicine in Florida."

Dr. William C. Ruffin Jr., Alachua: "I don't think anyone can be in disagreement with the proposal to upgrade the practice of medicine throughout the state and particularly in the mental institutions. I do think this is the wrong way to go about it. That's what we are talking about—the state hospitals. Dr. Rogers says if licensure is required by 1972 he will lose his staff. State institutions are primarily staffed by physicians who are qualified for licensure except for citizenship, so cannot get their licenses for five years."

Dr. Flipse spoke in favor of Dr. Wright's motion, stating that he had a staff of nine physicians at the University of Miami and they are all licensed. He suggested that higher salaries was the answer.

Dr. James B. O'Connor, Gadsden-Liberty: "Whether or not the legislature raises the salaries, it would be impossible to staff the state hospitals with licensed physicians. We have some physicians who are licensed in other states, but there is no reciprocity with Florida. Most of them, however, cannot get a state license for five years because of the citizenship requirement. It is a question of who is going to look after these patients."

Dr. Scottie J. Wilson, Broward, urged the House of Delegates to consider Dr. Rogers' problem and not put him in the position of being unable to staff the state hospitals. He also asked the Florida Medical Association to aggressively seek to have the legislature allow Dr. Rogers to offer higher salaries.

The Vice Speaker asked Dr. Wright to withdraw his motion so as to be parliamentarily correct. Dr. Wright complied.

The Speaker clarified the matter by saying that the motion was the recommendation in the Handbook on page 44, item 8, "Require that all physicians employed by state institutions have Florida licenses by January 1, 1972."

Dr. William W. Thompson, Okaloosa, suggested that the state mental institutions should be allowed at least as much leeway as would be allowed the medical schools under the proposed law.

Dr. Walter E. Murphree, Alachua, warned that if this House of Delegates acts precipitously, irreparable damage could be done. He said that the recommendations for the Medical Practice Act are still under study and that many suggestions are still being considered.

Dr. Murphree moved that this matter be tabled for further study.

Motion carried.

Dr. Roberts: "On page 47 (Handbook) at the bottom of the page, Recommendation No. 4 should be deleted."

Dr. Donegan: "This is the same thing we just voted on and it has been tabled."

Dr. Roberts: "The Reference Committee recommends adoption of the Judicial Council report as amended."

Motion carried.

"The Supplemental Report of the Committee on Archives was considered and the Reference Committee recommends the following additions:

June 1967, Jack Corbitt, M.D., Bay County

April 1968, Roderick C. Webb, M.D., Bay County

"The Reference Committee recommends adoption of the Supplemental Report of the Committee on Archives as amended."

Motion carried.

Judicial Council

JOHN J. CHELEDEN, *Chairman*

Council:

The Judicial Council met on September 9, October 14 and December 10, 1967.

The Council conducted a hearing for a member of the Association charged with unprofessional and unethical conduct in the practice of medicine. The member was reprimanded for inept medical judgment in the practice of medicine but the Council found no indication of any dishonest or illegal activities by him. The Council also took steps to improve the conditions existing in the area in which he practiced.

Emergency Rooms:

The Council considered several contracts for emergency room coverage at hospitals throughout the state with the following findings:

Halifax District Hospital, Daytona Beach—The Council found the following objectionable provisions in the contract for emergency room coverage.

1. The guaranteed per-shift salary is unethical.
2. The doctors are not billing separately and collecting separately.
3. The distribution of the receipts of professional fees is disputable.
4. Separate accounts on monies collected are not maintained.

The Volusia County Medical Society was contacted and it is working with the staff to correct the unethical arrangements.

St. Mary's Hospital, West Palm Beach—The Palm Beach County Medical Society was advised that the St. Mary's Hospital in West Palm Beach is offering a guaranteed annual income for an emergency room physician which is unethical. To date no reply has been received.

Memorial Hospital, Ormond Beach—The Volusia County Medical Society was advised that the Ormond Beach Memorial Hospital is offering a guaranteed annual income for an emergency room physician which is unethical, and the county society is working with the medical staff to correct the unethical arrangements.

South Miami Hospital—The Council reviewed its action of one year ago wherein it found the South Miami Hospital contract for emergency room coverage unethical in that it offers guaranteed annual income. Although the hospital had since that time reworded the contract, it still provided for the guaranteed salary.

Recommendation:

1. That the Dade County Medical Association be advised of the situation at the South Miami Hospital and request that the Dade County Medical Association provide a current status report of the emergency room contract at this hospital.

St. Vincent's Hospital, Jacksonville—The proposed contract for emergency room coverage at St. Vincent's Hospital was considered by the Council and in cooperation with the administrator of the hospital the contract was corrected to comply with the policy of the Association.

Sarasota General Hospital—The Council was under the impression that the Sarasota General Hospital was hiring physicians for the emergency room on a salary basis and the Sarasota County Medical Society was requested to correct this unethical situation. The Council was later informed that this was not the actual situation and actually the emergency department was organized on an ethical basis and not in violation and the Council remanded its action, commending the Sarasota County Medical Society and the Sarasota Hospital for its fine organization in staffing of the emergency room.

Recommendation:

2. The Chairman recommends that the emergency room at the Sarasota General Hospital be approved; and further it be used as an example for other hospitals to follow.

Statement of Policy—"Salary" of Physicians

Recommendation:

3. That a salary may be paid to a physician for time spent in administration and supervisory capacity but not for patient care.

That the Association's policy on guaranteed salary be clarified to state that it is not unethical for a physician to accept a salary for supervisory, educational and administrative activities or his presence; but that it shall be unrelated to how many patients he sees or how much money he collects from the patients for services rendered them; and that fees for treatment of patients shall continue to be billed in the physician's name and disposed of by the physician rendering the service.

That any physician employed in a hospital in any capacity should be employed and approved by and be a member of the medical staff of the hospital.

That all funds disbursed to the physician should be under the control of the medical staff; and where grants and monies are received for patient care, it should be in the name of the medical staff of the hospital.

Resolution No. 65-10—One Board of Medical Examiners

Recommendation:

4. That the Judicial Council is of the opinion that no further consideration of One Board of Medical Examiners is deemed advisable at this time, as nothing new has been presented in its favor.

Recommendation:

5. That the Franklin-Gulf County Medical Society now has the required number of active members to retain its charter and that it be allowed to do so.

Recommendation:

6. That it is not proper for physicians to participate in credit corporations of which the purpose is to finance accounts of those doctors who are stockholders of the corporation.

The Council reviewed the by-laws of Hillsborough County Medical Association and Pinellas County Medical Society which are in conflict with the Association's By-Laws regarding provisional members. The county societies were contacted and steps are being taken by them to amend their by-laws to conform with FMA by-laws requirements.

The Council approved the articles of incorporation of "Auto-Path Inc.," a corporation formed to allow three physicians to join together in the ownership of equipment used in their practice and for this equipment to be owned by a business corporation.

Recommendation:

7. That classified advertising which contains information contrary to policies of the Association not be accepted for printing in the Journal.

At the direction of the Executive Committee, the Council investigated a matter concerning a member reportedly referring his patients to a specific drug store for prescriptions. The Council advised the member concerned that it is unethical for a physician to direct any patient to any particular pharmacy, as there should be free choice of pharmacy as well as free choice of physician. The matter is still under consideration by the Council.

The subject of academic enrichment funds and faculty compensation at Florida's two medical schools is under review by the Council.

A postgraduate seminar, for which co-sponsorship had been granted by the Executive Committee, had added as a presenter an osteopathic hospital in Jacksonville after co-sponsorship was granted. The Council took the position that although the Council recognizes that postgraduate education falls under the purview of another council within the Association, the participation of Doctors Hospital in Jacksonville in the Florida Tuberculosis and Respiratory Disease Association Seminar places this activity within the realm of ethics; that the Association's co-sponsorship of the seminar be withdrawn, and that the Florida TB and RD Association be advised of this withdrawal because of the participation of Doctors Hospital; and that Duval County Medical Society, the Association's Committee on Postgraduate Education and its Council on Voluntary Health Agencies, and the Florida Academy of General Practice be so notified; and that since the original co-sponsorship was granted in good faith and the added participation of Doctors Hospital was made without our knowledge, it will not be considered unethical for members of the Association to attend the seminar.



Attending the past president's breakfast were (seated from left) Drs. Stewart, Day, Palmer, Jones, McEwan, Zellner, Thomas, (standing from left) Milton, Hampton, Wachtel, Annis, Jack, Roberts and Quillian.

6 0 0 2 9 8

The Council reviewed and approved the proposed Articles of Incorporation of the St. Vincent's Hospital Staff Association.

The Council referred to its Committee on Medical Licensure an inquiry concerning the Lamaze-Pavlov Technique of Painless Childbirth for review. This is still under investigation.

Corporate Practice of Medicine

The Council reviewed, at the request of the Executive Committee, the Association's policy on corporate practice of medicine to determine the most expeditious manner of implementation. The Council requested reports of the current status of corporate practice of medicine within the Florida Society of Internal Medicine, Florida Society of Pathologists, Florida Radiological Society, Florida Neurosurgical Society, Florida Society of Neurology, and all county medical societies.

Recommendation:

8. Whereas, The Attorney General of the State of Florida, in a letter dated March 25, 1955, to Homer L. Pearson, M.D., secretary-treasurer of the State Board of Medical Examiners, ruled that the corporate practice of medicine directly or indirectly in the state of Florida is illegal, and

Whereas, On several occasions the Florida Medical Association has requested the Florida State Board of Medical Examiners to deputize as members of the Board certain physicians for investigative purposes; therefore be it

RESOLVED, That the Florida State Board of Medical Examiners be requested to proceed to investigate the unauthorized practice of medicine by corporations and to reconsider deputizing the Association's Committee on Membership and Discipline for the enforcement of this provision.

Recommendation:

9. That the Committee on Membership and Discipline, in cooperation with the county medical societies, implement the Association's policy regarding the corporate practice of medicine.

The Council reviewed and approved the proposed by-laws of the Alachua County Medical Society.

The chairman of the Council is working with Florida's medical schools to institute courses in medical ethics and jurisprudence in all three medical schools in the state.

A county general hospital registered a complaint concerning two members with the county society. The Council asked the county society for a report of the progress concerning this complaint. The county society provided the Council with such report and the Council agrees with the recommendations made by the county medical society. A letter of commendation was sent to the officers and appropriate committee handling this matter.

The Council answered an inquiry of a county medical society concerning denial of a membership application by advising that the county society can deny membership; it can admit an applicant as a provisional member but not grant full membership unless it wishes to do so.

The Council reviewed and approved the revised charter and by-laws of the Brevard County Medical Society.

The Council approved the following statement of policy regarding responsibility of a medical staff of a hospital to the governing body of the hospital:

"Granting the legal and moral responsibility of a medical staff to respond as a corporate entity to the governing body of a hospital, said staff is not required to relinquish self-government and the right to organize and control its internal functions as pertains to the practice of medicine and professional decisions insofar as these are not in violation of any law and are within the authority granted by the by-laws and the rules and regulations duly adopted; specifically, the medical staff of any hospital has the right to organize a committee that satisfies the law, by-laws rules and regulations, and all relevant medical organizations and have this committee controlled by and answerable to the staff; and said medical staff is not required to accept the arbitrary imposition of such committee organization by the governing body, answerable to the governing body in the person of the administrator and not to the medical staff; indeed, it would be unethical for a medical staff to do otherwise."

Washington-Holmes County Medical Society

The Council considered information from the Washington-Holmes County Medical Society advising that only three physicians now practice in the area and requesting that their charter be made inactive.

Recommendation:

10. That the charter of the Washington-Holmes County Medical Society be declared inactive and its members allowed to seek membership in an adjoining society.

The Council considered the by-laws of the Columbia County Medical Society and requested them to revise their by-laws to allow a provision for non-licensed doctors of medicine to hold some type of associate membership to conform to FMA By-Laws.

In response to an inquiry from a member of the Association who is serving on a local utilization committee, the Council ruled that the Association's policy "where osteopaths are admitted to practice in a hospital in which doctors of medicine practice, it has been held to be unethical for the doctor of medicine to have any professional relationship with the osteopath. This includes consultations, supervising the work of the osteopath through review of medical records, tissue committees, etc., or giving any other indication of professional recognition" applies also to utilization committees of nursing homes or extended care facilities.

The Council again requested the State Board of Health to differentiate between M.D. and D.O. hospitals in its listings, and was advised by the State Board of Health that this will be done in the next published listing.

One appeal is pending for a former member expelled by his county medical society.

The Council has under review a complaint regarding the death of a child at the Florida Diabetic Camp in Immokalee. This investigation has not been completed at the time of this report.

As directed by the House of Delegates, the officers of the Association and the Judicial Council conducted a hearing for all interested parties—i.e., county society officers, medical schools, state agencies—on October 14 in Orlando. Following this meeting the Judicial Council met with officers and representatives of the Board of Medical Examiners. It recommends to the House of Delegates the following amendments to the Medical Practice Act. (In the interest of brevity only the highlights are presented in this report. A copy of the entire revision is available to any interested member and the Reference Committee.)

At its meeting October 14, 1967 the Judicial Council of the Florida Medical Association adopted the following recommendations regarding changes in the Medical Practice Act for consideration by the Board of Governors.

1. Recommend as a matter of principle that the Medical Practice Act be amended and more precisely defined to include the ancillary areas of practice within the purview of the State Board of Medical Examiners.

2. Inclusion in the new Medical Practice Act of a statement that no privileges granted under any other limited Medical Practice Act should in any way restrict the M.D. from performing any procedure covered by that Act.

3. That the State Board of Medical Examiners have injunctive powers to control infractions of the Medical Practice Act by individuals with a limited license which goes beyond their limitation.

4. Give the Board of Medical Examiners investigative powers.

5. Provide that physicians in a residency program approved by the Council on Medical Education of the American Medical Association may remain in such program for a period of four years without a Florida state license except by special action by the Board of Medical Examiners. This should also apply to internships approved by the Council on Medical Education of the AMA.

6. Retain the Basic Science Board.

7. At the discretion of the Board of Medical Examiners, a physician licensed in another state or otherwise eligible to take the Florida examination except for lack of citizenship who is assuming a permanent full time faculty position at an accredited Florida medical school be allowed a limited license for a period not more than one year at the same location and if his tenure at this medical school is terminated, his temporary license shall be terminated, such license to be renewable not more than four consecutive one-year renewals on an annual basis. This shall be called a medical faculty license.

[8. Require that all physicians employed by state institutions have Florida licenses by January 1, 1972. (Tabled.)]

9. Recertification by the State Board of Medical Examiners of any physician coming to Florida to practice medicine whose license was issued more than five years previously, without first proving his competence, which may include successfully completing the examination.

10. Make the following changes in the wording of the Medical Practice Act:

Amend Section 458.04 to provide $50 per diem while attending to official business, plus mileage.

Amend Section 458.041 to provide that the director should be a doctor of medicine licensed under this statute.

Section 458.06—retain the annual registration fee of $10.

Section 458.11—delete the word "written" so that oral examinations may be given if deemed appropriate by the Board.

Remove Section "K" on page 6.
(t) on page 7 should read "violates a lawful order of this Board."

Section (aa) on page 8 should be included on the registration form.

Section (g) and (h) on page 9 should be deleted.

Section (9) on page 9 after the words "of a physician," the words "acceptable to the Board" should be added.

Page 10, Section 458.121—delete from second and third line the words "or any assistant director or investigator." In this same section, sixth line, delete the words "or employee."

Page 12, item (6), seventh line, change the words "one member of the Board" to read "two members of the Board."

Page 16, Section 458.14—add to the end of the last sentence in the first paragraph the words "in this state."

Page 18, delete item (7).

Page 18, item (10), amend to read: "to adopt or incorporate by reference the Principles of Medical Ethics of the American Medical Association. . . ."

Page 19, item (12), broaden to include all chapters of Florida Statutes which are pertinent.

Specifically exclude professional service corporations as they could not be considered as practicing corporate medicine.

Give authority to investigate barbiturate and narcotic violations.

In definition of the practice of medicine, say "physical and/or mental condition" instead of "physical condition."

Recommendation:

11. As requested by the House of Delegates in 1967, the Council considered the Basic Science Boards and recommends to the House of Delegates that the State Board of Medical Examiners in the Basic Sciences be retained.

Council considered numerous other items received from individual members, county societies and other agencies which were disposed of in a satisfactory manner.

The following opinions were rendered in response to inquiries from members during the past year:

67-1: The Council concurs in the opinion of the chairman concerning a physician's right to refuse or accept a case when covering a hospital emergency room that no matter what the physician's feelings (personal or otherwise) may be regarding any patient requiring service, the fact that this patient applied to the emergency room of the only hospital in the locality would make it obligatory on his part to see that the patient received the necessary service either through his personal attention or that service would be provided by another physician with arrangements made by him (the physician covering the emergency room).

67-2: Physician ownership of hospitals is ethical.

67-3: It is ethical to accept promissory notes and postdated checks in payment for professional services rendered.

67-4: It is not unethical for physicians to use the same nursing home facilities that osteopaths use, providing there is no professional association; that it is unethical for physicians to serve on utilization committees with osteopaths.

Committees:

Committee on Archives—The Archives Committee of the Florida Medical Association has transacted its business during the past year through individual meetings of the chairman with committee members, correspondence and a telephone conference on February 1, 1968.

At the first meeting of the House of Delegates, Thursday, May 11, 1967, our committee held a brief memorial service in which it recognized the members who had joined the Association between the years of 1932 and 1935 and called for a moment of silent prayer for those members of our Association who had passed on during the preceding year. We also attached ribbons to the badges of the members who joined between 1932 and 1935 and on Friday, May 12, 1967, we held a reception for these members. Eleven (11) members attended and participated in an hour of good fellowship and yarnspinning. The committee plans a similar memorial service and a reception to honor those who joined the Society during the years 1936 and 1937 at this year's annual Association meeting.

During the year we have continued to solicit completion of Archives Data Forms from those members who failed to complete these forms. As it is compulsory for each new member to complete such a form before obtaining full membership, we are doing very well on the new members but there are still a number of the old members who have never completed their forms.

Under the able guidance of Dr. James J. DeVito, the medical history museum in connection with the St. Augustine Restoration Program has made further progress. The Board of Governors of the Florida Medical Association suggested the solicitation of voluntary contributions from the members as a method of funding this project. It is anticipated that this method will be utilized within the next few weeks. In addition, at the annual meeting of the House of Delegates, Dr. DeVito will introduce a resolution from the St. Johns County Medical Society that each member of the Association be assessed $1.00 a year for the maintenance of the museum.

The committee's Historical Marker Program is gradually progressing and it is planned to set the first marker at the home of Dr. Joseph Y. Porter, the first health officer of the state of Florida, in Key West at the time of the next annual meeting. In August of 1967 with the cooperation of the editor of the Journal of the Florida Medical Association, the Archives Committee sponsored a historical issue of the Journal. A similar issue is planned for August of 1968.

During the year our project to collect information for a history of medicine in Florida has progressed steadily with the obtaining of information from members of the Association including a copy of the memoir left by a frontier woman physician of the Okeechobee area, Dr. Anna Darrow. Members of the Association who know of similar diaries or other information relative to the history of medicine in Florida, are urged to contact the chairman of the Archives Committee.

Beginning in January of 1967 with the aid of a research grant, we have hired a scholar to search the Spanish archival material for information about medicine during the Spanish Period. This project has gone along very nicely and our grant has been renewed for another year; this should permit completion of the search of all the material that is readily available. The information so gathered will appear in an article on medicine during the Spanish Period in a future issue of the Journal of the Florida Medical Association and will be integrated into the general history of medicine in Florida when that is finally composed.

Supplemental Report
Committee on Archives

The Association has lost a number of its fine members during the past year and a list of these names is given below.

February 1967
- Maxwell D. Goodless—Broward

May 1967
- Shatteen T. Blalock—Orange
- H. Foxworth Horne—Duval
- Maximilian M. Kafka—Dade
- Earl H. Roberts—Duval
- Peter B. Wright—Orange

June 1967
- Jasper B. Dowling—Jackson-Calhoun
- John C. McSween Jr.—Escambia
- Jack Corbitt—Bay

July 1967
- Turner E. Cato—Dade
- Sterling E. Wilhoit—Gadsden-Liberty
- David R. Young—Putnam

August 1967
- Roger J. Arango—Dade
- Robert S. Baldwin—Lee-Hendry
- William C. Blake—Hillsborough
- David L. Mendelblatt—Pinellas
- Paul L. White—Pinellas

September 1967
- Johnston L. Chereskin—Sarasota
- David W. Exley—Dade
- George N. Leonard—Dade
- William J. McGovern—Marion

October 1967
- Charles F. Dillon Jr.—Orange
- John D. Gallagher—Volusia
- Thomas L. Glennan—Clay
- Thomsen-von Colditz Grambow—Brevard
- Samuel M. Wells—Duval

November 1967
- Bessie S. French—Dade
- Arthur J. Wallace—Hillsborough

December 1967
- Charles A. Born—Escambia
- Alpheus T. Kennedy—Escambia
- J. William Martin—Orange
- Joseph J. Ruskin—Hillsborough
- Ralph M. Wimbish—Pinellas

January 1968
- Blanche A. Burgner—Sarasota
- Turner Z. Cason—Duval
- Charles T. Dunham—Pinellas
- Hollis F. Garrard—Dade
- Marion F. Johnson—Lee-Hendry
- Wm. W. McKibben—Dade
- Rufus J. Pearson—Dade

February 1968
- William J. Barge—Dade
- Donald M. Christoffers—Alachua
- Willard H. Cleveland—Brevard
- Frederick L. Patry—Manatee

March 1968
- Cecil C. Collins Sr.—Duval
- Robert O. Lyell—Dade
- John H. Mason Jr.—Dade
- John E. Maines Jr.—Alachua

April 1968
- Frederic S. Huntington—Palm Beach
- Roderick C. Webb—Bay

Grievance Committee—There was no meeting of the Grievance Committee in the past year. All grievances received directly by the Association were referred to the respective county medical societies for investigation and action. The Committee made routine follow-ups on all grievances in which the reports had not been received within a six-month period. In one instance it was necessary for the Association to assume original jurisdiction and to make its own investigation. This involved a charge of being overcharged. In this case the doctor's charges were found to be reasonable and the complainant was so informed. It has been my experience that the county medical society grievance committees are doing a very good job in handling their grievances on a local level.

Committee on Medical Licensure—The Committee met with representatives of Florida medical schools, component medical societies, specialty groups, State Board of Medical Examiners, Basic Science Board (telephone), unlicensed and licensed Cuban physicians and various state governmental departments, to assess effectiveness of the Medical Practice Act and to consider possible solutions to present and future inequities in the law.

The Board of Medical Examiners during the past year examined for licensure 676 physicians and issued 659 licenses.

Investigations of charges filed with the Board of Medical Examiners resulted in hearings and the following action:

- 5 licenses suspended for two years; suspension not enforced and applicants placed on probation.
- 1 license suspended for 30 days; enforced
- 1 license suspended for 1 year; enforced
- 1 license revoked; revocation suspended, with licensee placed on probation.
- 4 reprimands
- 29 probation hearings
- 8 licenses reinstated after hearing at termination of suspension
- 6 applicants denied permission to take examination after hearing before the Board.

Recommendations:

1. No change in reciprocity or endorsement policy.

2. Special one year temporary teaching privileges for American physician, limited to medical school designated. (Certain other restrictions)

3. Injunctive powers for State Board.

[4. All physicians (except federal and residents in approved training programs) to be licensed by 1972—Tabled]

"The Reference Committee considered the report of the Council on Special Activities in the Handbook and recommends that it be adopted as printed. However, we would like to point out that the Woman's Auxiliary to the Florida Medical Association has requested guidance and suggestions and more energetic support in their activities for the future, as was reported to the House of Delegates by the President of the Woman's Auxiliary. We, the Reference Committee, concur and further suggest to the Board of Governors that this also include financial support for the Woman's Auxiliary activities."

Motion carried.

Council on Special Activities

JOHN D. MILTON, *Chairman*

Council:

There has been no occasion for a meeting of the Council on Special Activities during the past year. The individual committees have been available during the year and the chairmen have been most cooperative in every way and the Council expresses its thanks to them for their work.

There has been no formal meeting of the Committee on Advisory to the Woman's Auxiliary during the past year inasmuch as all the activities of the Auxiliary are moving along smoothly and without let-up.

The Board of Past Presidents held its annual breakfast at the time of the FMA annual meeting and in compliance with the By-Laws, H. Phillip Hampton, M.D., was designated to serve on the Judicial Council as a representative of this Board.

The FMA delegates to the AMA were present along with officers and staff at the June 1967 annual meeting in Atlantic City and its Clinical Meeting in November held in Houston, Texas. Actions taken by the House of Delegates sessions have been reported in the AMA news, the JAMA and the Journal of the FMA.

"The Reference Committee considered the President's Annual Address presented at the first meeting of the House of Delegates and wishes to express its deep appreciation to the President for the excellence of his presentation. However, we would like the privilege of disagreeing with him slightly when he says, '. . . . I am not a seer, and . . . . I am treading dangerous ground in looking into the future . . . .' We appreciate the insight and the depth with which our President can see into the future and we likewise are indebted to him for his calling to our attention the trends of future medical practice—the pitfalls we will encounter if we are not alert—and the adjustments we must make in the coming age of electronics communication and paramedical practices. We recommend that our President's address be adopted and suggest to each member of the Florida Medical Association that he reread this brilliant address when it is published in the Journal."

Motion carried.

(Complete text of President's address begins on page 615.)

"The Reference Committee considered the Remarks of the Speaker of the House, commends him for his suggestions for expediting the business before the House, and recommends adoption of his remarks."

Motion carried.

(Complete text of the Speaker's Remarks begins on page 621.)

"The Reference Committee considered Resolution 68-4, Otolaryngology, in the Handbook, and recommends that it be approved as printed. Since the implementation of this resolution requires a change in the Association's By-Laws, the Reference Committee also recommends approval of the following By-Laws change. For clarification, the recommended changes appear in bold face:

"Chapter IX—Committees, Section 1—Organization, 9th paragraph: "The Council on Specialty Medicine: Committees on Anesthesiology, Dermatology, General Practice, Internal Medicine, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedics, Otolaryngology, Pathology, Pediatrics, Plastic Surgery, Psychiatry, Radiology, Surgery, and Urology."

Motion carried.

Resolution 68-4

Otolaryngology
West Bitzer, Delegate

Whereas, The Board of Governors of the Florida Medical Association granted recognition to the Florida Society of Ophthalmology and the Florida Society of Otolaryngology, which replaced the Florida Society of Ophthalmology and Otolaryngology, and

Whereas, The By-Laws of the Florida Medical Association call for one representative on the Council on Specialty Medicine for both Ophthalmology and Otolaryngology; therefore be it

RESOLVED, That the By-Laws of the Florida Medical Association be amended to have a representative for Ophthalmology and a representative for Otolaryngology appointed to the Council on Specialty Medicine.

"The Reference Committee considered Resolution 68-8, History of Medicine Museum, in the Handbook. The committee wishes to state that it considers the method of funding the Museum suggested in Resolution 68-8 impractical. We do recognize as a worthy project of the Association the establishment of a repository for the history of

medicine in our state, which has been so illustrious in the past and is expected to be more so in the future. We would urge that this resolution be referred to the Board of Governors for action to furnish sufficient funds in the immediate future to insure that the project has a substantial foundation upon which to become established."

Dr. James J. DeVito, St. Johns: "I wish to thank Dr. William Straight and also the Board of Governors for their assistance. I would like to invite all members of the Florida Medical Association to visit this museum, which dates back to 1774, to see what we have and contribute your relics. Let's make this a credit to the state."

Motion carried.

Resolution 68-8

History of Medicine Museum
St. Johns County Medical Society

(Not Approved—Referred to Board of Governors)

Whereas, The House of Delegates of the Florida Medical Association at its meeting in 1966 adopted Resolution 66-15, authorizing a committee to study a museum of the History of Medicine in Florida at St. Augustine, and

Whereas, Recommendations for implementation of this medical museum have been completed and presented to the Board of Governors, and

Whereas, A request for voluntary contributions from the membership has resulted in only sixty dollars ($60.00) being contributed for this purpose, and

Whereas, Approximately $15,000 is needed for implementation of this project, which is not currently available from the operational assets of the Association, and

Whereas, The St. Johns County Medical Society has voted to donate $250 toward this project; therefore be it

RESOLVED, That the House of Delegates authorize the assessment of the membership, one dollar ($1.00) per year for three years, to be used for the History of Medicine Museum in St. Augustine, Florida.

Dr. Roberts: "The Reference Committee considered Resolution 68-12, Membership Classifications, and recommends that it be adopted as presented. The committee would further suggest that the Board of Governors study the problem of maintenance of active membership for members moving from one society to another within the state of Florida."

Motion carried.

Resolution 68-12

Membership Classifications
Dade County Medical Association

Whereas, There are many variations and inconsistencies in the classification of membership in state and county medical societies and most of these classifications are different from those used by the American Medical Association, and

Whereas, These differences can be the cause of confusion and difficulty in the transmittal of dues and the prerogatives of membership at the various levels of organized medicine: Now, therefore, be it

RESOLVED, That the Florida Delegation to the AMA request that a study on membership classification be undertaken by AMA with representatives of state and county medical societies to recommend uniform membership categories which can be established at all appropriate levels of organized medicine.

"The Reference Committee considered Resolution No. 68-14, Medical Meetings, and recommends that it be adopted as presented."

Motion carried.

Resolution 68-14

Medical Meetings
Broward County Medical Association

Whereas, The ever increasing number of meetings with required attendance are producing a deleterious effect upon the personal, professional and social life of physicians; and

Whereas, This is a national problem with requirement rules established by national bodies: Be it, therefore,

RESOLVED, That the House of Delegates of the Florida Medical Association requests that the American Medical Association, through its appropriate committee, investigate this problem and attempt to set guide lines that will reduce the number of meetings with required attendance.

"I wish to thank the members of Reference Committee No. III, Drs. William A. Van Nortwick, W. Mahon Myers, Russell B. Carson and Richard C. Clay, for their indulgence and for their sound thinking and unanimous conclusions on each item discussed. I would also like to thank those who came to our committee to voice their desires and opinions. I also want to thank Mrs. Wanda Bain, our recording secretary, because not only did she do a good job of recording, but she was also very helpful in clarifying some of the things on which we were quite hazy, and I thank her very much.

"Mr. Speaker, that concludes the report of Reference Committee No. III."

Report of Reference Committee No. IV
Legislation and Miscellaneous

Dr. Francis C. Coleman, Chairman: "The Committee's recommendations on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"The report of the **Council on Legislation and Public Agencies** was carefully considered and the following actions were taken:

"Under **Committee on National Legislation**, the following correction was made at the request of the Committee on National Legislation: In the second paragraph of the Committee's report, delete the second sentence: 'The following is a summary checklist of legislative issues which will necessitate increased liaison and communication with our Florida Congressional Delegation.' This sentence had been previously deleted and was included in the report in error.

Motion carried.

The Reference Committee recommends commendation of the Committee on National Legislation for its very diligent work on behalf of the members of this Association.

"Your Reference Committee recommends approval of the report of the **Subcommittee on Liaison with State Agencies**, and its recommendation that additional physicians be placed on the State Welfare Board by the Governor, if this can possibly be arranged."

Motion carried.

"Under the report of the **Committee on State Legislation** there are eight recommendations, which the Reference Committee considered individually.

"1. **Blood Banking**: Your Reference Committee recommends that the provision of blood be considered a service and not the sale of a commodity; therefore, it does not carry an implied warranty. Your Reference Committee recommends the inclusion of this item in the state legislative program."

Motion carried.

"2. **Retention of the Basic Science Law**: Your Reference Committee recommends that the Florida Legislature be requested to repeal its *previous action to abolish the Basic Science Law.** In view of the time factor as explained by the Committee on State Legislation, this should be given top priority." (*Amended.)

Dr. Sackett moved to amend this recommendation of the committee by changing the words "repeal its previous action to abolish the Basic Science Law," to "retain the Basic Science Law."

Motion to amend carried.

Main motion carried as amended.

Dr. Coleman: "3. **Revision of the Medical Practice Act**. Your Reference Committee is in favor of revision of the Medical Practice Act as



Reference Committee IV membership included Drs. F. C. Coleman, chm., T. M. Smith, W. H. Keeler III, H. D. Perry Jr. and F. J. Evans.

one of our legislative goals and recommends that this be given second priority."

Dr. Evans objected to the redundancy of the Medical Practice Act as proposed and said he understood that this was to be discussed on the floor but he had heard no such discussion.

Dr. Evans moved that this subject be referred to the Board of Governors for further study with professional advice and the results of their study be automatically approved for submission to the Florida Legislature.

Motion seconded.

Dr. Zellner explained that this had already been thoroughly studied, and that the report in the Handbook was just a condensation of some 50 pages which had been compiled from various past meetings. He thought it would be a mistake for the House of Delegates to try to go into the details of this law.

Dr. Haskell supported Dr. Zellner's remarks and also said that when this law gets to Tallahassee, it will be very carefully studied by every attorney in the state.

Dr. Cheleden, Chairman of the Judicial Council, explained that this subject was still being studied, deletions and additions are still being made and it was the intent of the Council to continue this work subject to the suggestions of any member of the Florida Medical Association. The report in the Handbook was merely a summary, and the Reference Committee did not have the final copy. This is still not final, and any suggestions will be welcome.

Dr. Russell B. Carson, Broward, explained that Reference Committee No. III had the advantage of having Dr. Cheleden, Mr. Nesbit (Attorney for the State Board of Medical Examiners), several members of the Board of Medical Examiners and others in their meeting who counseled them on various phases of the act. The committee was also furnished with one of the complete revisions of the Medical Practice Act for reference.

The Vice Speaker called for a vote on Dr. Evans' motion, which was defeated.

The recommendation of the Reference Committee carried.

Dr. Coleman: "4. **Therapeutic Abortion and Resolution 68-20:** Since Recommendation No. 4 of the report of the Committee on State Legislation and Resolution 68-20 dealt with the same subject, they were considered at the same time.

"Your Reference Committee recommends approval of the Recommendation No. 4—Therapeutic Abortion—of the Committee on State Legislation and recommends disapproval of Resolution 68-20."

Dr. Henry L. Wright Jr., Hillsborough: "This has been discussed last year, during the year and since we have been at this meeting. I move for call of the question."

Motion seconded.

The Vice Speaker called for a vote on the call for the question and stated that it would require a two-thirds vote of the House to pass.

Motion to call for the question carried.

Dr. Edward J. Lauth, Dade: "I rise to a point of personal privilege, which if you will check with Roberts' Rules of Order, reflects on the honor and the dignity of this House. There was a motion here which shut off a minority opinion upon a very, very serious question on which we feel we have the right to speak. We feel this parliamentary maneuver reflects upon the honor and the integrity of this House by not allowing us a minimal amount of time on a flimsy excuse to discuss the subject of therapeutic abortion. We do not wish to go into detail or rehash old things, but Resolution 68-20 was a different resolution."

Dr. Donegan: "I must rule you out of order, Dr. Lauth."

Dr. Lauth: "I would like to hear the parliamentary rule that makes me out of order."

Dr. Cook: "Your appeal was that this reflects on the dignity of this House. I do not agree with you, and will have to rule you out of order."

Dr. Lauth: "Then I appeal to the House to overrule the ruling of the Parliamentarian."

Dr. Cook called for a vote of the House on his ruling and the vote was conclusive in favor of the ruling of the Parliamentarian.

Motion was carried to approve the recommendation of the Reference Committee.

Dr. Coleman: "5. **Title XIX—Medicaid and Resolution 68-16:** These two items were considered together as they pertain to the same subject.

"With respect to Recommendation No. 5—Title XIX—Medicaid, your Reference Committee was informed that enabling legislation has already been enacted, and that the only thing required for implementation of this program is an appropriation to fund the program. (Amended.)

"At the same time, your Reference Committee considered Resolution 68-16 and recommends its adoption with the addition of the word 'fiscal' so the first 'Resolved' will read:

"RESOLVED, That the Florida Medical Association urge that such implementation be accomplished so the *fiscal* program is administered through an insurance carrier independent of any state agency,

"and that another 'Resolved' be added:

"and be it further,

"RESOLVED, That the Florida Medical Association urge the Legislature to so amend the present legislation.

"Your Reference Committee recommends that this resolution as amended and Recommendation No. 5—Title XIX, Medicaid, of the Committee on State Legislation be approved."

Dr. Harold A. Yount, Palm Beach: "I would like to commend the committee for this resolution but would like to amend it. I want no change in it as it is written except the following addition: To the first 'Resolved,' I would like to add: 'and that such carrier be instructed to abstain from experimentation as outlined in Section 402 of Public Law 90-248'."

Motion was seconded.

"I would like to explain that under Section 402 as interpreted in its guidelines by the Department of Health, Education and Welfare, the 'reasonable cost and reasonable charge' provisions are waived. In other words, usual and customary are waived.

"There is only one example of a guideline which HEW quotes and that is capitation—the English method.

"They even have the audacity to ask our own organizations to participate in their cut-rate medicine. To quote, 'The participation of private service benefit plans such as Blue Cross and Blue Shield should be encouraged and, finally, on such experimentations they propose to do the evaluation within their own department.'

"My friends, I ask you; please put this addition in. Let us try to stop any experimentation which negates usual and customary."

Motion to amend carried.

Dr. Sackett, Dade: "In the last line of the second paragraph, in talking about 'the only things required for implementation of this program is an appropriation to fund the program', I would like to add, 'and the approval of the chief executive of the state'." (Amended)

Motion to amend carried.

Original motion as amended carried.

Resolution 68-16

Title XIX
Dade County Medical Association

Whereas, plans are being formulated by the Florida Legislature for the implementation of Title XIX in the State of Florida: Now, therefore, be it

RESOLVED, That the Florida Medical Association urge that such implementation be accomplished so the fiscal program is administered through an insurance carrier independent of any state agency, and that such carrier be instructed to abstain from experimentation as outlined in Section 402 of Public Law 90-248; and, further, be it

RESOLVED, That the Florida Medical Association urge the Legislature to so amend the present legislation.

Dr. Coleman: "6. **Naturopathy Identification:** Your Reference Committee recommends the adoption of Recommendation No. 6 dealing with clear and proper identification of naturopaths."

Motion carried.

"7. **Utilization Review Committee Exemption from Liability and Resolutions 68-7 and 68-9:** Recommendation No. 7 of the Committee on State Legislation and these two resolutions were considered at the same time because they dealt with the same subject.

"Your Reference Committee recommends approval of Recommendation No. 7 and Resolutions 68-7 and 68-9."

Motion carried.

Resolution 68-7

Utilization Review Committee
Exemption from Liability
Duval County Medical Society

Whereas, The Duval County Medical Society feels that the actions taken by committees for the purpose of maintaining professional standards should be unencumbered by the possibility of libel action, and

Whereas, There is apparently no Florida law which currently exempts these committees, especially Utilization Review Committees from legal action; Now therefore be it

RESOLVED, By the Duval County Medical Society that we urge the Florida Medical Association House of Delegates to request the introduction of the following legislation act:

A BILL TO BE ENTITLED

AN ACT TO PROVIDE EXEMPTION FROM LIABILITY FOR MEMBERS OF COMMITTEES OF PROFESSIONAL SOCIETIES, HOSPITALS, SANITORIUMS, NURSING HOMES, REST HOMES, OR A MEDICAL STAFF OF ANY OTHER ORGANIZATION FORMED TO MAINTAIN STANDARDS: PROVIDING AN EFFECTIVE DATE.

Section 1. No liability or cause of action of any kind or character for damages or other relief shall arise or be enforced against any person who is a duly appointed member of a duly appointed committee of a state or local medical society or association, or a duly appointed member of a duly appointed utilization review committee or other committee of a staff of any hospital, sanitorium, nursing home, rest home, or a medical staff of any other organization, for any act or proceeding undertaken or performed within the scope of the functions of any such committee

which is formed to maintain the professional standards of the society, association, corporation or organization as established by its charter, articles of incorporation, or bylaws, if such committee member acts without malice.

Section 2. The provisions of this section shall not affect the official immunity of an officer or employee of a public corporation as it may exist or the sovereign immunity of the State of Florida.

Section 3. This section shall not be construed to confer immunity from liability upon any professional society, association, hospital, sanitorium, nursing home, rest home, or medical staff of any other organization. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a professional society, association, hospital, sanitorium, nursing home, rest home, or medical staff of any other organization, such cause of action shall exist as if the preceding provisions of this section had not been enacted.

Section 4. This act shall take effect immediately upon its becoming a law.

Resolution 68-9

Utilization Review Committee Exemption from Liability Alachua County Medical Society

Whereas, The Alachua County Medical Society is cognizant of the need for legislation to exempt from liability members of committees formed to maintain standards, be it

RESOLVED, That the Alachua County Medical Society favors passage of such legislation; and be it further

RESOLVED, That a sample bill, published infra, be forwarded to the Florida Medical Association for its consideration.

A BILL TO BE ENTITLED

AN ACT TO PROVIDE EXEMPTION FROM LIABILITY FOR MEMBERS OF COMMITTEES OF PROFESSIONAL SOCIETIES, HOSPITALS, SANITORIUMS, NURSING HOMES, REST HOMES, OR A MEDICAL STAFF OF ANY OTHER ORGANIZATION FORMED TO MAINTAIN STANDARDS: PROVIDING AN EFFECTIVE DATE.

Section 1. No liability or cause of action of any kind or character for damages or other relief shall arise or be enforced against any person who is a duly appointed member of a duly appointed committee of a state or local medical society or association, or a duly appointed member of a duly appointed utilization review committee or other committee of a staff of any hospital, sanitorium, nursing home, rest home, or a medical staff of any other organization, for any act or proceeding undertaken or performed within the scope of the functions of any such committee which is formed to maintain the professional standards of the society, association, corporation or organization as established by its charter, articles of incorporation, or bylaws, if such committee member acts without malice.

Section 2. The provisions of this section shall not affect the official immunity of an officer or employee of a public corporation as it may exist or the sovereign immunity of the State of Florida.

Section 3. This section shall not be construed to confer immunity from liability upon any professional society, association, hospital, sanitorium, nursing home, rest home, or medical staff of any other organization. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a professional society, association, hospital, sanitorium, nursing home, rest home, or medical staff of any other organization, such cause of action shall exist as if the preceding provisions of this section had not been enacted.

Section 4. This act shall take effect immediately upon its becoming a law.

"8. The Board of Governors recommends first priority be given to the revision of the Medical Practice Act and second priority be given to retention of the Basic Science Law:

"Your Reference Committee approves this recommendation, with the amendment that the order of priority be reversed as alluded to in Items 2 and 3 above."

The Vice Speaker ruled that no action was necessary, since items 2 and 3 had already been approved.

Dr. Coleman: "Your Reference Committee wishes to commend the Committee on its fine report and also recommend to the Board of Governors that it provide the necessary funds to enable this committee to implement its very ambitious plans for continuing and expanding its legislative program.

"The value of the Capitol Medical Dispensary in implementing our state legislative program was noted and your Reference Committee is impressed with the need for continuing this Capitol Medical Dispensary during the legislative sessions. More active voluntary participation by Florida physicians is needed in the operation of this Capitol Medical Dispensary. Such active voluntary participation is recommended by your Reference Committee."

No action taken.

"The recommendation of the Subcommittee to the Commission on Aging was carefully considered and your Reference Committee recommends approval of this recommendation."

Motion carried.

"Mr. Speaker, this concludes the report of the Council on Legislation and Public Agencies."

Council on Legislation and Public Agencies

JERE W. ANNIS, *Chairman*

Council:

All of the committees and subcommittees have been continuously active throughout the year and it is my opinion that liaison with the various agencies has never been better. Likewise, our image in all of these areas is better than at any previous time. A demonstration of this is the governor's committee on health matters, in which he has recognized, through membership on the committee, key people throughout the state identified with the Florida Medical Association.

Special praise should be given again this year to Dr. Haskell and the Committee on State Legislation for the untiring and exhaustive job that they have done during our frequently convened legislative sessions throughout the past year. Never before have we had such authority, such dedication and such effectiveness. It is recommended that the Board realize that an even more complex, sophis-



Exhibit Hall

ticated and larger organization and activity will be inevitable in legislative sessions in the future, if we are to maintain the hard-won position which we have.

Dr. Von Thron has also done an excellent job on the national legislative level, and here too, our efforts must be continuing and unremitting.

Committees:

Committee on National Legislation—The Committee has directed attention and efforts toward legislation pertaining to health and occupying a large portion of the time of the U.S. Congress. A record number of more than 1,100 medically related bills were introduced in the first session of this Congress. This compares with a little over 850 introduced in the first session of the preceding 89th Congress. The first session of the 90th Congress adjourned December 13, 1967, and at that time the following ten major legislative proposals which affect medical care had been forwarded to the President for signature. Such legislation involved the areas of mental health, health planning, Medicare, vocational rehabilitation, extension of OEO programs, air and water quality control, the doctor draft, product safety, flammable fabrics and Appalachian regional development. More than 75 bills were introduced that, if adopted, would have changed, or in some way broadened, the Medicare program.

Many important health care legislative proposals are predicted for the last session of the 90th Congress. As in the past, this is to be accomplished through our Key Contact and Alternate Contact Physicians.

Congressional Visitation—The FMA Key Contact Physicians are scheduled to meet with the Florida Congressional Delegation in Washington on April 23-24, 1968, for liaison purposes and to discuss national legislation of interest to the medical profession. It is planned that a supplemental report will be submitted summarizing this visitation.

The Committee on National Legislation endorses and encourages wide participation by all FMA members in FLAMPAC, especially in this pivotal election year. Dr. Louis Murray, FLAMPAC Chairman, should be commended for his outstanding contribution and leadership during 1966-68. We also feel FLAMPAC warrants more active support, interest and direction from the House of Delegates.

Subcommittees:

Liaison with Federal Agencies — Department of Health, Education and Welfare.—Liaison was continued through both of these subcommittees through the chairman on the State Welfare Board and on the medical advisory board to the Division of Vocational Rehabilitation throughout the year. The regular meetings of these boards were attended and we participated in the preparation of a budget for our implementation of Title XIX and in the establishment of a new medical advisory committee to the Department of Public Welfare. This committee was composed of members of the FMA and met with the Board on March 10, 1968. The position and policies of the association have been kept before the Welfare Board and the HEW.

Recommendation:

That additional physicians be placed on the State Welfare Board by the Governor, if this can possibly be arranged.

In regard to Title XIX, it is noted that the federal restrictions now sharply curtail the amount of money that will be expended under this title, limiting it by the state's participation in the Aid to Families With Dependent Children program.

Committee on Veterans Administration—Since Veterans Administration has agreed to pay usual charges for care to veterans under Home Town Care Program, there have been no complaints nor activities of the committee during the past year.

Committee on State Legislation—The purpose of this report is to summarize the activities of the 1967 session of the legislature and to present recommendations regarding future committee activities and legislation to be sponsored and/or supported by the FMA during the next regular session.

Activities and Highlights—The 1967 legislative session adjourned July 14 following an additional twenty working days extension. For the first time in over a 100-year history, the legislature experienced a two-party system with 28 Democrats and 20 Republican Senators and 80 Democrat and 39 Republican Representatives.

A record number of 1,784 Senate and 3,397 House bills were introduced which included an unprecedented number relative to health care. The medical profession, through FMA staff and individual physicians, fulfilled its professional obligation to the citizens of Florida by sponsoring and offering support, amendments and opposition to more than 75 to 80 bills during the session. Although a definite position of support or opposition was not necessary or required on each of these bills, comprehensive study and careful evaluation was given to each by FMA staff, legislative legal counsel and the chairman of the FMA state legislative committee.

Also, for the first time in history, three important highlights were experienced. First—the four following FMA physician members served in the legislature: Senators John J. Fisher, M.D.(R), Jacksonville and David

C. Lane, M.D.(R), Fort Lauderdale; and Representatives Richard S. Hodes, M.D.(D), Tampa and Walter W. Sackett Jr., M.D.(D), Miami; Also, Miley Miers, D.D.S. (D), Tallahassee, served in the House.

The physician members were extremely active in fulfilling their legislative duties and especially were they most helpful regarding health legislation.

Second—The FMA Woman's Auxiliary held a "First Legislative Day" on April 27 in Tallahassee to observe the legislature in action. On this date they observed a well-attended joint House and Senate Health & Welfare Committee hearing on the abortion bill. During their visit, many made personal calls on their senators and representatives.

Third—A dispensary was provided for the members of the legislature and staff employes. This endeavor, sponsored by FMA and supplemented by several pharmaceutical supply and equipment companies, was well received. Fifty-three physician members of FMA from throughout the state volunteered their services for one or more days to staff the dispensary. Evidence of need for such a service is indicated by the fact that more than 500 persons were provided medical attention by the visiting physicians and physician members of the legislature.

Each volunteer physician was introduced daily in both the Senate and House and recognized as the "visiting physician" for the day. Their visit provided an opportunity to observe firsthand the legislature in action and permitted them to personally visit with their state legislators to become better acquainted and to discuss legislation of interest to the medical profession as well as other legislation of local interest.

During the 1967 session, the Association sponsored the following bills which were passed:

1. Hospitalization of Mentally Ill.
2. Consent for Autopsies.
3. Medico-Legal Deaths and Toxicological Needs.
4. Title XIX—Medicaid.
5. Clinical Laboratory—inspection and regulations.

With regard to Title XIX—Medicaid legislation was later vetoed.

Therapeutic Abortion—The abortion bill sponsored by FMA incorporated the essential provisions of the model penal code prepared by the American Law Institute. It failed to pass.

Recommendations:

Specific items to be recommended as part of the Association's legislative program are as follows:

1. Blood Banking
2. Retention of the Basic Science Law
3. Revision of Medical Practice Act
4. Therapeutic Abortion
5. Title XIX—Medicaid
6. Naturopathy Identification
7. Utilization Review Committee Exemption From Liability
8. The Board of Governors recommends first priority be given to revision of the Medical Practice Act and second priority be given to retention of the Basic Science Law. (R.C. reversed this priority.)

Subcommittees:

Liaison with State Agencies—There were many meetings with Dr. Frank Fort, director of the Crippled Children's Commission, until recently. Recently, the Governor has appointed three doctors of medicine, members of the Association, to the Commission, and the Commission has appointed one of its own members, Dr. Irving Hall, to be liaison with the Commission and the Florida Medical Association.

Commission on Aging—By correspondence with the chairman of the Commission on Aging, liaison has been maintained. Currently the Commission is without an executive director, former Senator Clyde Galloway having resigned.

Recommendation:

That FMA review medical representation on the Florida Commission on Aging and indicate interest in making recommendations for appointment of physician representative when term of present physician representative expires.

Alcoholic Rehabilitation—This committee has continued to function as a member of the Advisory Council for the Florida Alcoholic Rehabilitation Program. We are holding periodic regular Council meetings involved with policy making, guidance, and review of the functions of both the Avon Park Hospital and the Outpatient Clinics serving various geographical areas of the State of Florida. We have been active in carrying out our functions in the treatment of voluntary alcoholism patients as well as carrying out educational activities, research, and the annual school for training and informing various professions involved with alcoholism problems in the State of Florida.

Board of Health—Continued liaison with FMA from State Board of Health. No action by State Board of Health taken regarding medical activity until recommendations of FMA are secured. State Board of Health refused to correspond with isolated groups of Florida Medical Association and channel all advice and recommendations through the parent organization.

Division of Mental Health—Meeting of the committee on Oct. 27, 1967 with Drs. Rogers and Eaton of the Division of Mental Health for discussion of recommendations of the mental health legislation; studies of community mental health programs; current problems of state hospitals; and planning for the conference of Key Mental Health leaders of the state.

The annual meeting of Key Mental Health Leaders was held on Feb. 25, 1968. This meeting is held to summarize all the activities on a professional level which includes members of the legislature, divisions of state government plus voluntary and professional mental health represen tatives.

A member of our committee will represent the FMA at the AMA 14th Annual Conference of State Medical Society Mental Health Representatives in Chicago in 1968.

Strong support of the legislature to allow emergency involuntary hospitalization of the mentally ill.

Our committee tentatively plans to visit the Lake Butler Reception and Classification Center and State Hospital of the Division of Corrections when completed. This is a project our committee has strongly recommended and supported.

Dr. Coleman: "We go now to items from the Report of the Board of Governors.

"Your Reference Committee reviewed the first item under referrals by the House of Delegates, which was a report by the Board of Governors on the disposition of Substitute Resolution 67-3 and 67-8, Wilbur J. Cohen. Since this report was presented for information, no action was required by your Reference Committee.

"Next, Comprehensive Health Planning, P. L. 89-749; Partnership for Health Amendments of 1967—P. L. 90-174.

"Testimony was presented recommending that the physician representation on the 52-man Florida Health Planning Advisory Council be increased

to at least 20, the majority of whom should be physicians in private practice. Your Reference Committee is in accord with this recommendation in view of the broad scope of the functions of this council, which is deeply involved in all matters of planning for the health and welfare of the citizens of Florida.

"Your Reference Committee recommends approval of this portion of the report of the Board of Governors and urges the Board of Governors to request these changes in the composition of the Florida Health Planning Advisory Council."

Motion carried.

"On Action No. 13—FLAMPAC—your Reference Committee recommends approval of this action of the Board of Governors.

"Testimony was presented which indicated that in past years the Florida Medical Association had provided additional funds for the use of FLAMPAC for educational purposes. Your Reference Committee was impressed with the importance of the availability of these funds and recommends that the Board of Governors give serious consideration to again making these funds available."

Motion carried.

(See Board of Governors report, page 646.)

"On Resolution 68-13—Medical Quackery—your Reference Committee is in agreement with the intent of this resolution, but believes that the language of the resolution is not clear.

"Your Reference Committee, therefore, recommends that this resolution be approved in principle, but that it be referred back to the Broward County Medical Association for clarification and resubmission either to the House of Delegates or to the Board of Governors."

Motion carried.

Resolution 68-13

Medical Quackery
Broward County Medical Association

(Approved in Principle, Referred back to sponsor)

Whereas, Some practitioners of the healing arts in the State of Florida are purported to be claiming an ability to cure maladies for which they are, by lack of training and education, manifestly unable to do, and

Whereas, Other practitioners are using methods which are not acceptable by standards of good medical practice, and

Whereas, The laws which provide punitive measures for such persons are not commensurate with such action, be it therefore

RESOLVED, That the Florida Medical Association propose and support an Act to the next session of the Florida Legislature, which would make a felonious act of such practices, and delineate adequate punishment for persons who are convicted under a charge of Medical Quackery.

"Resolution 68-19—Highway Safety Laws: Testimony was presented indicating that there is a medical advisory committee to the Department of Public Safety and the suggestion was made that the chairman of this medical advisory committee might be a suitable physician appointee to the Highway Safety Commission.

"Your Reference Committee recommends approval of this resolution."

Resolution 68-19

Highway Safety Laws
M. Eugene Flipse, M.D., Delegate

Whereas, Public Law 89-564 known as the National Highway Safety Act of 1966 was signed into law by President L. Johnson on September 9th, 1966 and

Whereas, the Florida Legislature of 1967 passed the following major highway safety bills:

1. *Senate Bill No. 151* is Governor's Enabling Act empowering the Governor to do all things necessary in behalf of the state to obtain full benefits of the National Highway Safety Act of 1966.

2. *House Bill No. 10* referred to as Ambulance Enabling Act, permitting county commissions to contract for ambulance service and regulate same.

3. *House Bill No. 12* referred to as Ambulance Enabling Act, permitting municipalities to contract for ambulance service and regulate same.

4. *Senate Bill No. 171* covers central issuance of drivers' license. Covers original applications, license and renewals, as well as expiration of license and delinquent licenses.

5. *House Bill No. 126* covers the requirement of protective safety helmets, glasses, goggles, and other safety regulations pertaining to motorcycles and other two-wheel motor vehicles.

Whereas, the Governor of our State has appointed the Governor's Highway Safety Commission to control allocations of 267 million dollars available from the Federal government.

Whereas, the eleventh standard set by the National Highway Safety Act and covers emergency medical service and is one of the top priority, be it

RESOLVED, by the Florida Medical Association that a member be recommended for appointment by our Governor to the Governor's Highway Safety Commission to represent the practicing physicians of our state who treat the injured and examine the dead. This member should be closely tied to the Governor's Steering Committee on Health.

Dr. Lauth, Dade: "I request that the item previously tabled, Item 9, in the report of Reference Committee No. II be removed from the table and discussed." (This was an item on Therapeutic Abortion).

Motion was seconded.

The Vice Speaker said this would require a two-thirds vote of the House and called for a voice vote.

Motion lost.

Dr. Lauth again commented that this was a reflection on the dignity of the House.

Dr. Donegan: "Dr. Lauth, this House was long and patient in listening to you last year. You are out of order."

Dr. Jude, Dade: "I do not know whether this is in order, but I would like to request that the President appoint a committee to study life, death and organ transplantation from the standpoint of the Florida Medical Association."

Dr. Donegan: "I think this is commendable, but I do not believe we can bring it up at this time. You may recommend this to the Board of Governors."

Dr. Coleman: "The Reference Committee wishes to express its appreciation to all those who attended its meeting and expressed their views, which were of great benefit to the committee in its deliberations.

"The chairman also wishes to express his thanks to the members of the committee, who were so diligent and cooperative in this effort: Drs. Tim M. Smith, William H. Keeler III, Henry D. Perry Jr. and Franklin J. Evans, and to our able secretary, Mrs. Mae Mason."

"This concludes the report of Reference Committee No. IV."

Dr. Cook, Speaker, resumed the Chair.

Report of Reference Committee No. V
Medical Economics

Dr. J. Maxey Dell Jr., Chairman: "The Committee's recommendation on each item will be submitted separately and we request that each item be acted upon separately before proceeding to the next.

"Your Reference Committee recommends acceptance as information of the report of the Council on Medical Economics.

Motion carried.

"We approve the Supplemental Report of the Council on Medical Economics, Committee on Relative Value Studies, and recommend its adoption."

Motion was carried to remove from the table that portion of the report of Reference Committee No. I dealing with Relative Value Studies.

Motion was carried to approve the recommendations of both Reference Committees No. I and No. V dealing with Relative Value Studies.

Council on Medical Economics

JACK A. MaCRIS, *Chairman*

Council:

The Council on Medical Economics met on January 13, 1968, at which time reports of committee activities with recommendations were considered and acted upon.

Individual Responsibility Program was presented to the Council and unanimously approved. Assistance in disseminating program information was requested of the Committee on Health Insurance in their liaison activities with the Florida Health Insurance Council. Informational program material, with claim form, has been mailed to all FMA members urging their voluntary acceptance.

Committee on Health Insurance—The committee report, with recommendations, was considered and approved with the exception of Item III (See Board of Governors Report).

Report of Committee on Advisory to Blue Shield—The Committee report was considered and approved by the Council with the exception of Recommendation 2 with reference to review of Blue Shield claims (See Board of Governors Report).

Committee on Relative Value Studies—A summary report was presented by the chairman who advised the Council that the committee has completed its work in revising the Relative Value Studies. The revised manual entitled "1968 Relative Value Studies of the Florida Medical Association" has been mailed to all FMA members and is available at cost to all interested persons.

Committee on Hospitals and Extended Care Facilities—At the time of the Council meeting the chairman discussed the committee activities and there were no recommendations to be presented for Council consideration at that time. The written committee report is included as part of the full Council report.

Committee on Members Insurance—The Council was advised as to the number of physicians currently participating in the FMA insurance plans. The committee, working through Marsh & McLennan, Inc., which serves as administrator for the Association, is pleased to announce that both benefits and premiums for the Office Overhead Expense Plan have been revised, effective May 1, 1968, in order to have the program competitive with other group plans.

Committees:

Committee on Advisory to Blue Shield and Fiscal Intermediaries—The Committee met on September 17, 1967, at which time the following items were discussed



Sitting as Reference Committee V were Drs. J. M. Dell Jr., chm., W. Bitzer, M. B. White, H. W. Johnston and J. C. Pringle Jr.

with resulting recommendations. The recommendations contained in this report were presented to and were approved by the Council on Medical Economics with the exception of Item II of the recommendation with reference to review of Blue Shield claims. As noted in the report of the Committee on Health Insurance, this recommendation *was not* approved by the Council on Medical Economics but *was* approved by the Board of Governors at the time of its January 14, 1968, meeting.

1. Committee of 17 Newsletter—The previously used newsletter of the Committee of 17 was discussed and it was thought that this news medium served as an excellent educational vehicle and that it should again be reinstituted at an early date.

Recommendation:

That the Committee on Advisory to Blue Shield reinstate the previously used Committee of 17 Newsletter for mailing to all physicians in the state.

2. Review of Blue Shield Claims—Problems experienced in handling Blue Shield claims were thoroughly discussed. The committee reviewed a prepared statement by the Insurance Review Committee of the Dade County Medical Association, and in discussing the matter, it was pointed out that there was apparent confusion and misunderstanding due to the position of FMA and the requirements of the Medicare law. It was emphasized that the basic problem was whether or not the local insurance review committee is to continue its present activities in reviewing both private health insurance claims and Blue Shield claims, and, if so, whether or not such review was to be done in a like manner. The committee was advised that private insurance companies have always accepted and abided by the recommendations of the local committee; however, the committee's recommendations on at least one occasion have not been acceptable to the Blue Shield claims committee. In further discussion, it was pointed out that determination of "usual" and "customary" and "reasonable" fees is most difficult and that preferably this should be done only at the local level and not use the state as a whole. It was suggested that possibly Dade County should be considered as a separate locality and that the DCMA Insurance Review Committee should continue to determine what is usual and customary for that particular locality. Should this not be considered practical or acceptable, then there should be no reason to continue the insurance review committee activities if the local committee's recommendations are to be overruled by the state level Blue Shield claims committee.
3. Blue Shield Contract for U.A.W—The request of the United Automobile Workers' Union for usual and customary Blue Shield coverage for their 3,000 Florida members was discussed. It was mentioned that the coverage requested was to be similar to that approved as the "U" contract for steelworkers and, to date, there have been no problems in handling this contract.

Other Items:

1. Report re Resolution 67-25—In discussing the summary report regarding Resolution 67-25 entitled "Blue Shield" the committee was advised that all subscribers covered by the complementary policy to Medicare have been notified that they can continue their present Blue Shield coverage or may reinstate. Presently, Blue Shield is mailing out and responding to about 100 inquiries per week, and it appears that many of the eligible subscribers desire the complementary coverage but, to date, 30 subscribers have retained or reinstated their Blue Shield coverage.

2) "K" Contract—At the time of the last meeting of the Committee, action was taken to urge that Blue Shield develop an upgraded contract for offering to persons who pay Blue Shield direct or who apply on a non-group basis. In keeping with this action, Blue Shield has developed and made available the "T" contract which is comparable to the "K" contract with the exception that the "T" contract includes underwriting the provision to exclude pre-existing conditions. This is the first time that non-group subscribers have been offered an upgraded contract and all direct pay subscribers with the "V" contract are again being given the option to upgrade to type "K." The new contract provides options to include a chance to increase the Blue Cross hospital room allowance to $18 or $24, and it is felt that the majority of subscribers will elect the $24 benefit.

3) Blue Shield Informational Program—With the assistance of Blue Shield staff, the presidents, secretaries and executive staffs of county medical societies have been advised of the availability of an informational Blue Shield program. The response to this initial offer was not what was hoped for and, because of this, the Professional Relations Committee of Blue Shield has agreed to offer further assistance in preparation of written program material using script and slides. It was agreed that committee members would offer their assistance by asking that county medical societies agree to having this type of program presented at one of their monthly meetings. It was also mentioned that hospital staff meetings be utilized to present the program—especially the larger hospitals. In addition to using the program for Blue Shield informational purposes, it would, in most instances, necessitate discussion of the Medicare Part B program for which Blue Shield serves as Florida carrier. It was suggested that when each committee member contacts the program chairman, executive staff, officers of county medical societies and/or chairman of the medical staff of the hospitals that they emphasize that the purpose of the program is to have physicians better understand that Blue Shield is representative of physicians in Florida and that their cooperation and involvement in Blue Shield affairs is to their best interest. Secondly, the informational program will be to acquaint them with new contracts and new areas of coverage being offered by Blue Shield.

4) Report of Medicare Part B—The committee received a summary report regarding Medicare Part B program and Blue Shield's use of the electronic data processing equipment for accumulation of statistics indicative of physicians' charges throughout the state. Statistics to date indicate that charges for the twenty most common procedures under Medicare Part B and under Blue Shield contracts closely parallel each other.

5) Utilization Review—In discussing activities regarding utilization review, it was mentioned that Blue Shield has accumulated some valid statistical information, especially on a few physicians with extraordinary office practices. It was further mentioned that utilization is of primary concern to Blue Cross but that Blue Shield will become more involved.

6) Group Practice Prepayment Program—It was suggested that the Committee should look into the matter of prepayment programs and especially those group practice plans similar to the Kaiser-Permanente Plan and other panel programs. It was also mentioned that informed persons could be asked to meet with the Committee to discuss this matter at some future meeting.

Committee on Health Insurance—The Committee met on January 10, 1968, in Miami and following the committee meeting there was a joint meeting with representatives of the Florida Health Insurance Council and the Dade County Medical Association Insurance Review Committee.

The following items were discussed with resulting recommendations by the Committee which were presented to and acted upon by the Council:

I. Purpose and Goals of Committee—The purpose and goals of the committee, as approved by the Board of Governors and House of Delegates, were reviewed, and it was agreed that the committee reaffirm approval of them and that this reaffirmation be disseminated to all county medical societies and appropriate representatives of the Health Insurance Council.

Purpose—"The purpose is to insure fair mediation and to create a sound relationship between the physicians of the state of Florida, the health insurance industry and the patient (recipient of health insurance benefits)."

Goals

1) That the committee through its educational functions to the membership of the Florida Medical Association and the health insurance industry, attempt to develop and/or promote more adequate and responsible health insurance coverage.
2) To aid physicians in every possible manner in their understanding of the work of insurance review committees.
3) To assure that physicians are dealt with fairly and are protected when possible from inconvenience, harassment and embarrassment.
4) To assure that the insurance companies are dealt with fairly and requested to cooperate more fully with the physicians of the State of Florida.
5) To request that insurance companies be prepared to explain adequately the extent of coverage of given policies when the policies are sold.
   a. To assure that commercial carriers avoid putting the practicing physician in the middle of fee disputes when the patient is fully satisfied with the professional service and the fee but disturbed with insurance remuneration when he was lead to believe it would be complete.
6) The committee will educate to dispel the thoughts that insurance review committees and the state insurance committee are "tools of the insurance carrier" and/or "the police force of the profession."

The committee also considered the type of claims submitted for review by local insurance review committees. It was felt that in many instances the fee in question did not warrant review merely because the concerned carrier claims personnel had stated that "fee appears to be excessive" without indication as to the amount of excessiveness. In order to improve and expedite the administrative processing of claims submitted for review and to avoid further misuse of time and effort on the part of local committees, the committee approved the following recommendations:

1) That claims submitted for review by commercial health insurance carriers be sent directly to county medical society insurance review committees.
2) That in instances where a claim is submitted for review because it is felt that the fee is excessive, that the criterion for this determination be so stated and afforded to the county medical society insurance review committee.
3) That *all claims* submitted for review be first reviewed by competent medical authority.
4) That a letter be written by the Chairman of the Committee on Health Insurance to all component county medical societies and the Florida Health Insurance Council advising of these changes in procedure.

II. Hospital Staff Utilization Review Committees—The committee discussed in detail activities and functions of a hospital utilization review committee and, in doing so, recognized that such committees are still relatively new and much remains uncertain as to the effectiveness. Because of this, it was agreed that the Committee on Health Insurance should not become involved at this time.

It was further agreed that activities of a hospital staff utilization review committeee should remain a responsibility of a hospital medical staff to be exercised at the local level. An effective review mechanism is available in the review committee and it must be made to function. Otherwise, parties outside of the medical profession will assume the responsibility for the function of utilization review.

The committee further agreed that investigation as to availability of sources of funds to be used to compensate physicians for services rendered in reviewing claims of all types should be undertaken.

The committee, in continuing its liaison activities with Florida Health Insurance Council, has met and corresponded with insurance industry representatives regarding activities of insurance review committees, hospital utilization review committees and the Individual Responsibility Program developed by the FMA-IRP Committee.

Committee on Members Insurance—The Committee did not meet during the year, however, attention and consideration were given to several problem areas involving physicians who were denied issuance and/or renewal of coverage under the Association's Professional Liability Program. In considering the four cases involved, the general consensus of opinion, as expressed by committee members, was that desired limits of insurance should be made available to the involved physicians.

On February 28, 1968, the chairman met with FMA officers and staff, administrators of the Association's insurance programs, and carrier representatives to discuss the current status of the Professional Liability Insurance Program. In addition, attention was given to proposed revision of both benefits and premiums for the Office Overhead Expense Plan in order to have the program competitive with other group plans. Due to favorable experience, the Continental Casualty Company is to incorporate a 20% reduction which will make the Office Overhead Expense Plan competitive in all respects with other similar programs currently available. This rate reduction will be put into effect May 1, 1968.

The chairman's attention was called to the method which an independent insurance agency in the Miami area uses to solicit FMA membership participation in the Association-sponsored insurance plan. This matter was related to our insurance administrators with the request that such devious and spurious practices used by independent insurance agencies be stopped in that they are often times irritating to physicians.

Summary report of the number of participants in the FMA-sponsored insurance plans as of January 11, 1968, is as follows:

Professional Liability	2,311
Straight Excess Professional Liability	102
Million Dollar Umbrella (Employers')	387
Million Dollar Umbrella (Ins. Co. of N. America)	338
Owners', Landlords' & Tenants' Liability (Office Premises)	265
Accidental Death & Dismemberment	266
Catastrophe Hospital Expense	1,155
Disability Income Protection (Short Term)	659
Disability Income Protection (Long Term)	249
Preferred Physicians Plan (One Year Waiting Period)	68
Senior Income Plan	7
Office Overhead Expense Plan	408

Committee on Hospital and Extended Care Facilities—The following activities were carried out during the past year with certain recommendations included.

The Committee chairman or his designate attended during the past year:

a) The meeting in Orlando, Florida concerning community and county health planning organizations.
b) Meeting with other members of the Council on Medical Economics in Jacksonville, January 13, 1968.
c) The meeting with representatives of the Nursing Home Association, the Aetna Insurance Company, Blue Cross and Blue Shield, and the Florida Medical Association in January regarding definition of

custodial and skilled medical or paramedical care as it relates to extended care facilities.

d) The meeting in March in Jacksonville concerning hospital infections.

Recommendation:

That county medical societies and physicians throughout the state work to achieve physician membership on hospital boards as recommended by AMA and FMA. With the increased emphasis on patient care in and through hospital facilities, it seems essential that physicians have some voice and representation on the managing board of trustees of hospitals in the state of Florida. In some cases by-laws specifically prohibit the inclusion of physicians on these boards and these by-laws should be promptly changed.

Committee on Relative Value Studies—The Relative Value Studies Committee has been concerned throughout the year with formation of the 1968 Relative Value Studies Manual. This new revision is the result of several years of study, investigation and discussions. Based on the most recent California RVS Manual available and data developed in Florida, it is considered a considerably more complete, equable and up-to-date manual than the initial 1962 edition. Florida physicians are urged to study the 1968 edition and its various introductory sections with care.

The present committee has taken a position, endorsed by the Board of Governors, that, in view of an increasing number of new procedures and the need for continuing evaluation of relativity, regular study and more frequent revision of the Florida RVS is necessary if it is to be a useful and valid instrument for physicians and various third parties. It is considered that the most important task currently facing the committee is development of techniques and long-range plans for study of procedures and related fee structure patterns in Florida. A further planning meeting will be held in April to consider this important problem and a supplementary report will be issued by the committee following this meeting.

Supplemental Report
Committee on Relative Value Studies

These observations and recommendations are submitted following the April 7, 1968, meeting of the Committee on Relative Value Studies:

1) The Committee feels strongly that methods employed in formulation of the 1968 RVS manual should not be attempted again. Due to difficulty in promptly securing adequate information on procedures and fee patterns caused by lack of systematic statewide surveys, development of the manual was extremely difficult, frustrating and time-consuming. Attempts to produce the present manual began more than three years ago, during which the 1962 RVS became increasingly obsolete and, in the end, a large body of information had to be borrowed from the most recent California RVS to insure an up-to-date useful manual.

2) It is the opinion of the Committee that, as in other states, notably California and New York, some type of professional statistical assistance or consultation in collecting and interpreting necessary current data is essential for timely manual revision in the future. In this connection, the committee is actively investigating types of personnel and surveys used elsewhere and beginning an evaluation of resources which may be available in Florida for a continuing survey program.

3) It is recommended that the careful development of adequate continuing survey procedures and manual revision, including use of paid professional assistance, if necessary, be endorsed in principle with all proposals and working details subject to approval by the Board of Governors.

Dr. Dell: "From the Board of Governors' report, Resolution 67-20, Individual Responsibility Program, we recommend approval of the report."

Motion carried.

"From the Board of Governors' report, Resolution 67-22, Blue Cross-Blue Shield, we recommend approval of this report."

Motion carried.

"The Reference Committee recommends adoption of Board Action No. 2 FMA Relative Value Studies."

Motion carried.

"The Reference Committee recommends acceptance for information of Board Action No. 3, Medicare."

No action necessary.

"Your Reference Committee recommends adoption of Board Action No. 7, Blue Shield Claims Committee."

Motion carried.

"On Board Action No. 8, Workmen's Compensation, Dr. Robert E. Zellner presented his report as a member of the ad hoc committee appointed by the Florida Industrial Commission, stating that all negotiations for a change in payment on the basis of usual and customary fees had broken down.

"This committee recommends that the Board of Governors study this problem and provide a mechanism for institution of a suit by an individual physician, component county medical society or specialty group to test the validity of the FIC's refusal to provide payment of usual and customary fees as required by law.

"It is recommended that the FIC be notified that FMA no longer recognizes any fee schedule and information contrary to this being sent out to physicians be discontinued.

"It is recommended that FMA notify its membership that usual and customary billing of patient, employer or insurance company is legal according to testimony of legal counsel.

"In line with the recommendation of the Board of Governors suggesting that physicians of Florida use the principles of the IRP by presenting their bills for Workmen's Compensation services directly to the responsible person, it is recommended that this be emphasized to the members of the FMA and their cooperation requested.

"We move the adoption of Board Action No. 8 and the recommendations for its implementation."

Dr. Fred Butler, Collier, Member of the ad hoc committee: "It was a shock when Dr. Zellner told us that negotiations had broken down. We are now back where we started. I approve of these recommendations, but they involve litigation, which is a slow business, particularly when you sue the State of Florida. The Commissioner has said that he will issue some new regulations; we do not know what these will be. Perhaps we will be tossed some crumbs or a bone of some sort.

"My point in rising is to remind you that we did get something in our last painful negotiations —it was quite an increase over what we had many years ago. I think if we abdicate our position in Tallahassee, enter into litigation and have nothing else to do with them, we are only asking for trouble. We dislike the words 'negotiation', nevertheless, I think it behooves us to stay in close contact with what is going on in Tallahassee. Perhaps the Board of Governors in their wisdom will do this anyway, but here is the recommendation I wish to add as an amendment:

"It is recommended that the Board of Governors continue to maintain close contact with the Industrial Commission in an attempt to favorably influence Workmen's Compensation fee regulations promulgated by the Commission."

Motion to amend carried.

Motion as amended carried.

(See Board of Governors Report, page 646.)

Dr. Dell: "We recommend that **Resolution 68-17, Workmen's Compensation,** be adopted with the following amendment of the Resolved:

"RESOLVED, That the Florida Medical Association take whatever legal action necessary to secure the Workmen's Compensation fee arrangement providing usual and customary fees as required by law if approved by the legal counsel of the FMA."

Motion to amend carried and resolution as amended was approved.

Resolution 68-17

Workmen's Compensation
Dade County Medical Association

Whereas, It is apparently impossible for representatives of the Florida Medical Association to secure the cooperation of a majority of the Florida Industrial Commission in developing an equitable arrangement, as provided by law, for the payment of usual and customary fees for individuals covered by Workmen's Compensation: Now, therefore, be it

RESOLVED, That the Florida Medical Association take whatever legal action necessary to secure Workmen's Compensation fee arrangement providing usual and customary fees as required by law if approved by the legal counsel of the FMA.

Dr. Dell: "On **Board Action No. 9, Medicare Hearing Officer,** on the basis of new information received, the committee feels this is unnecessary and moves that it not be adopted. Mr. Schroder and Dr. William J. Dean, as well as the Chairman of the Committee on Health Insurance, felt that this could be accomplished through present personnel."

The motion, that is, the Board of Governors' recommendation, was defeated; therefore, the Reference Committee recommendation was approved.

"On **Board Action No. 11, Professional Liability,** your Reference Committee recommends that this be received as information."

No action.

"On **Board Action No. 12, Extended Care Facilities,** it is recommended that this be adopted and the implementation of this report should clarify the requirements for custodial and extended care and this information be sent to the physicians of the state. This should be accompanied by a request that the doctor provide more information to the utilization review committee of the extended care facility."

Motion carried.

"On **Board Action No. 18, Blue Cross of Florida,** it is recommended that this be received for information."

"On **Board Action No. 21, Determination of Fees,** a minority report will be submitted.

"It is felt that this Board Action should be divided into two parts and voted on separately.

"Part 1. Your Board approved the recommendation of the Committee on Advisory to Blue Shield and the Committee on Health Insurance that in determining usual, customary and reasonable fees localities not smaller than county size be considered."

Minority Report by one member, J. Maxey Dell Jr., M.D.:

"The division of the state into segments in reality creates multiple new fee schedules, with constant revision of these schedules requested by the different areas, with the problem of defining boundaries and the increased difficulty in administering such a program, and it is felt by the minority member that this part should not be adopted."

The Speaker explained that a vote of "aye" would approve the recommendation of the Board of Governors and the majority of the Reference Committee, and a vote of "nay" would approve the minority report.

Dr. Dell, in discussion of his minority report, went on to say that the state is already under a differential fee plan on an individual basis and he was afraid that this would cause a splintering effect rather than a unifying one.

Dr. Samuel M. Day, Past President: "I was the one that led the fight last year for state-wide limitation. After having it in effect for a year, I think we have primarily accomplished what we set out to do. We have profiles which are reasonably accurate on different areas of Florida and since there are pressures in favor of removing that limit, I would no longer favor the state as a whole. I would go along with the recommendation of the Board."

Dr. John M. Gunsolus, St. Lucie-Okeechobee-Martin: "I would like to recommend adoption of the minority report. As we move into the area of governmental medicine, these things are all computerized, and I heard the expression in the Reference Committee that this is a method to divide and conquer us. It will be hard to fight for 17 different fee schedules in this state. The little areas will get lost; we should fight to maintain what we have."

Dr. Butler, Collier: "Gentlemen, this involves more than just dividing the state into political and economic subdivisions for Medicare. I realize that more is being charged in many of the urban areas than in the rural areas. If, however, we develop insurance review committees state-wide, this involves developing fair, well-organized insurance review committees which will function for the state as a whole. In some areas, there will not be enough doctors to develop effective committees. I feel we are also in many ways infringing on many state programs which are operating on the usual and customary concept. I believe Vocational Rehabilitation has grown to about a $13 million program and these people are now in position to ask that their fees be regionalized. This will be a complicated nightmare. Therefore, I am asking that perhaps this should be reconsidered or tabled until we are better organized."

Dr. Hampton moved for the question and the motion carried.

Motion to approve the Board of Governors action and the recommendation of the majority of the Reference Committee carried by a vote of 96 to 92.

Dr. Dell: "Part 2. That in a case where the Blue Shield Claims Committee considers a billed fee excessive, this bill be referred to the insurance review committee in the area involved; if the recommendation of the local insurance review committee is not acceptable to Blue Shield Claims Committee, the latter committee shall seek advice from the Committee on Health Insurance of the Florida Medical Association before making a final decision.

"Part 2 was not controversial and the committee recommends its adoption with the change of 'Health Insurance Council' to the 'Committee on Health Insurance'."

Dr. Day: "I would like to propose an amendment: that the words, 'this bill be referred to the insurance review committee in the area involved,' be changed to read, 'and the case is referred to the insurance review committee in the area involved.'

"It would be very bunglesome to refer every case to the local committees. Most of them can be taken care of in the office of Blue Shield."

Amendment carried.

Motion as amended carried.

(See Board of Governors Report, page 646.)

Dr. Dell: On Resolution 68-1, Service Policies of Blue Shield, this type of policy is being phased out slowly, and to do it immediately would require going before the Insurance Commissioner of the state and would create a great deal of confusion. For this reason, we recommend this not be adopted."

Motion was defeated; Resolution 68-1 was not approved.

"On Resolution 68-2, Escalator Clause in Relative Value Studies, it was felt that this Resolution is contrary to the present concepts of usual and customary fees and relative value studies. For this reason the committee recommends this resolution not be adopted."

Motion was defeated; Resolution 68-2 was not adopted.

"Resolution 68-6, Blue Shield of Florida, Inc., the Reference Committee recommends adoption of this resolution."

Motion carried.

Resolution 68-6

Blue Shield of Florida, Inc.
Orange County Medical Society

Whereas, The Orange County Medical Society believes that Blue Shield of Florida has the ability to provide the best type of pre-paid medical care protection for the citizens of Florida, and

Whereas, It is essential that doctors retain control of the practice of medicine, and not lose it to the government, or any other non-medical party; therefore be it

RESOLVED, That the Orange County Medical Society recommends to the Florida Medical Association that Blue Shield of Florida, Inc., be maintained and strengthened in every way possible; and that individual doctors and county medical societies give the Plan their wholehearted cooperation and support. It is further

RESOLVED, That the resolution be submitted to the House of Delegates of the Florida Medical Association meeting for approval in session at Hollywood, May, 1968.

"Resolution 68-15, Florida Individual Responsibility Program, the Reference Committee recommends adoption."

Motion carried.

Resolution 68-15

Florida Individual Responsibility Program
Orange County Medical Society

Be it RESOLVED, By the House of Delegates of the Florida Medical Association, that the Individual Responsibility Program Committee is re-affirmed and continued, and further be it

RESOLVED, That the Board of Governors of the Florida Medical Association is instructed to continue to promote the principles of the Individual Responsibility Program.

Dr. Dell: "The Chairman wishes to express his thanks to the members of the committee who were so diligent and cooperative in this effort: Drs. West Bitzer, Millard B. White, Harold W. Johnston and James C. Pringle Jr., and to our secretary, Mrs. Arlene Cassens."

"This concludes the report of Reference Committee No. V."

The Chair recognized Dr. Richard C. Dever, Dade, to present a non-controversial resolution.

Dr. Dever read the resolution, which was seconded and passed unanimously.

Resolution 68-24

Editor of The Journal
Richard C. Dever, M.D., Delegate

Whereas, This House of Delegates has observed the growth and success of The Journal of the Florida Medical Association since 1961; and

Whereas, The Editor of The Journal of the Florida Medical Association is relinquishing his post after this felicitous period for which he is so personally responsible: Therefore, be it

RESOLVED, That this House of Delegates go on record as expressing its deepest appreciation to Doctor Thad Moseley for his efforts, which have been of such great value to this Association and that a suitable copy of this Resolution be presented to him as evidence of the gratitude and affection of this House of Delegates.

Dr. Ray E. Murphy Jr., Chairman, Golf Committee, announced the winners of the golf tournament:

Duval County Medical Society Trophy for Low Gross—Dr. Henry H. Bryant of Coral Gables

Runner-up—Dr. Curtis G. Rorebeck of Tampa

Low net—Dr. Frank B. Hodnette of Pensacola

Runner-up—Dr. Joseph C. Von Thron, of Cocoa Beach.

For prizes, the following names were drawn:

Dr. F. Joseph Burns Jr., St. Petersburg

Dr. William W. O'Connell, St. Augustine

Dr. James T. Shelden, Lakeland

Dr. Albert D. Rood, Jacksonville

Dr. Paul J. McCloskey, Tampa

Dr. Ray E. Murphy Jr., Pompano Beach

The Speaker called for nominations for the office of President-Elect of the Florida Medical Association.

Dr. J. Maxey Dell Jr., Alachua: "The Alachua County Medical Society has unanimously endorsed a man for President-Elect of the Florida Medical Association, and they have given me the honor of presenting this man's name. He fulfills all the requirements that we demand in a real man.

"He has worked long and hard for organized medicine. He is a member of the Alachua County Medical Society, the Florida Medical Association, the American Medical Association, a Diplomate of the American Board of Surgeons and a Fellow of the American College of Surgeons; a member of the Florida Association of Industrial and Railway Surgeons, the Southern Medical Association and the Florida Association of General Surgeons. He is a Fellow of the Southeastern Surgical Congress. He was President of the Alachua County Medical Society in 1952, chairman of the Florida Medical Association's Committee on Advisory to Blue Shield from 1956 to 1959, a member of the Board of Directors of Blue Shield of Florida from 1959 to date, a member of the Board of Directors of Blue Cross of Florida from 1960 to date, Chief of Staff of Alachua General Hospital from 1959 to 1961 and head of the Department of Surgery at the Alachua General Hospital from 1963 to date, Chairman of the Fee Schedule Committee of the Florida Medical Association 1961 to 1963, a member of the Board of Governors of the Florida Medical Association from 1961 to 1965. He is the present Chairman of the Committee on Medical Schools of the Florida Medical Association.

"He was a member of the Board of Directors of the Gainesville Chamber of Commerce from 1958 to 1960, a lieutenant colonel in the Medical Corps of the United States Army from 1941 to 1946.

"He enjoys the complete trust and confidence



Dr. Babers is escorted to the rostrum by Drs. J. Maxey Dell Jr. (left) and William C. Thomas Sr.

of his fellow physicians both locally and statewide. The old Greek cynic could have thrown away his lantern if he had met this man. Strength of character is his; ability he has in abundance; love of medicine and his fellowman fills his life and this is all united in harmony by a deep and abiding faith in a Supreme Being. Without fear I will say to this man, 'you lead and I will follow.' Never have I felt so safe as with such a man as Henry Jennings Babers, who is now proposed to you by the Alachua County Medical Society for President-Elect of the Florida Medical Association."

Dr. Warren W. Quillian, Past President: "You have heard Dr. Dell reiterate many of the accomplishments of this man whom we have known and admired through many years as one of our most stalwart members. There is no need to repeat his accomplishments. During all of these assignments, an outstanding characteristic has been his dignity, his dependability and his good judgment in fulfilling the duties and tasks associated with the job to be done. He has served his patients and fellow physicians faithfully and tirelessly. Having served with him on many occasions, I can attest personally to these traits and to my admiration for his accomplishments. If we may quote from Dr. Walter Judd in his wonderful address to us last Friday, it can be said truthfully of Henry that he is a man 'with a cool head and a warm heart.' His mature experience deepens his understanding of our mutual problems.

"I consider it a privilege and an honor to second the nomination of Dr. Henry J. Babers Jr. as President-Elect of this organization, both as an individual and on behalf of the Dade County Medical Association which supports me in this sentiment."

Dr. William C. Thomas, Past President: "I have probably known Henry Babers longer than anyone here—since 1944. I have always felt that the presidency of this Association should seek the man and not man seek the office. Henry Babers is one of our finest citizens, one of our finest physicians and one of my best friends. I feel it is very much an honor to second his nomination."

The nomination was also seconded by Drs. Russell B. Carson, Broward; Robert E. Zellner, Past President, Orange; William C. Roberts, Past President, Bay; William J. Dean, Pinellas; Clyde M. Collins, Duval, and Francis T. Holland, Leon-Wakulla-Jefferson, who then moved that nominations be closed and the Secretary cast a unanimous ballot for Dr. Babers.

Motion carried.

Dr. Babers was escorted to the rostrum by Drs. J. Maxey Dell Jr. and William C. Thomas Sr.

Dr. Babers: "I am deeply honored and nothing further needs to be said. I am real happy that Dr. Thomas stayed over another day, and



Dr. Henry J. Babers, Gainesville, addresses the House upon his election as President-Elect.

I thank you, my comrades. I will try my best to be worthy of your trust."

Dr. Walter E. Murphree, Alachua: "We in Alachua County do appreciate the overwhelming support of our candidate. In line with Dr. Thomas' remarks, Dr. Babers did not seek this job. We had to persuade him to take it. Breaking precedent just a bit, we are presenting to Dr. Babers from the Alachua County Medical Society a plaque which reads: 'Henry J. Babers, President-Elect, Florida Medical Association, 1968, from the Alachua County Medical Society'."

Mrs. Babers was escorted to the rostrum by Dr. Billy Brashear of Alachua and Dr. Murphree presented to her a beautiful arm bouquet of red roses.

The Vice Speaker called for nominations for Vice President.

Dr. Joseph F. P. Newhall Jr., of Manatee: "Those of us who were privileged to hear those fine addresses on Friday by Dr. Judd and Senator Thurmond were inspired to renew our dedication toward a system of government based on right of the individual with minimal government regulation. As physicians, we were challenged to take a more active part in politics as a prerequisite to continuing our successful system. The members of the Manatee County Medical Society have been repeatedly challenged over the past few years in this same manner by the man we propose for the office of Vice President of the Florida Medical Association. He has shown by example, encouraged the hesitant, scoffed the lazy, trod on a few slow-moving toes; yes, I am sure has lost patients and a few friends due to his efforts, yet he constantly strove for the conservative leadership both in our nation and in our medical association. He currently serves as the only physician county chairman in the Governor's organization and has used his influence to assure that the Florida Medical Association and not lay politicians are consulted on state medical policies and appointments. He works for himself—not for a state agency or governmental bureau, but as a private solo practitioner of medicine, yet he finds time to do the political and governmental duties so necessary for the survival of our profession. He was one of the instigators and chairman of the committee that formulated the Individual Responsibility Program, as a means of keeping the third party out of our offices. He has served the state organization in many ways; as chairman of the Child Health Committee in 1963, as chairman of the Council on Medical Services in 1964, 1965 and 1966, as chairman of the Credentials Committee in 1964, as well as lesser positions in other offices, both at the state and county level. For the past two years he has been a member of the Board of Governors of this organization. He is currently a member of the Crippled Children's Commission for the State of Florida. He has the education we all have, the convictions most of us have and the energy and determination few of us have in pursuing these goals. True, by precedent, he possibly should not be considered for this office, as a man usually does not succeed himself. But, as a member of the FMA, we all have the desire to keep him in this office because of his beliefs, his activities and his accomplishments. At this time we can afford no less. I, therefore, take great pride by the unanimous decision of the Manatee County Medical Society in placing in nomination for the office of Vice President of the Florida Medical Association, Dr. Irving E. Hall Jr., our present Vice President, of Bradenton, Florida."

Dr. Day: "I would like to second the nomination of Dr. Hall. I think it is healthy for our organization that we can talk a man into serving as Vice President for another term. I think it is healthy that we have made the vice presidency something tangible in the organization, in that he serves on the Board of Governors and he has a real spot. This Irving Hall—what was said about him is really true. He is full of vim and vigor as they say I once was and it is good to have him there to build a fire occasionally under those old men on the Board. He builds fires wherever he goes. It gives me pleasure to second the nomination."

Nomination was also seconded by Dr. Edward G. Haskell Jr., Leon-Wakulla-Jefferson; Dr. James A. Winslow Jr., Hillsborough; Dr. Jesse W. Castleberry, Orange, and Dr. Gordon B. Carver, Broward, who said they had intended to present a candidate, but that his delegation had decided to defer their nomination and moved that nominations be closed and a unanimous ballot be cast for Dr. Hall.

Motion carried. The Vice Speaker announced that Dr. Irving Hall was unanimously elected.

The Chair called for nominations for Speaker of the House.

Dr. William F. Brunner, Jackson-Calhoun, nominated Dr. James T. Cook for re-election as Speaker of the House.

Dr. Henry L. Harrell, Marion, moved that nominations be closed and Dr. Cook be elected by acclamation.

Motion carried. The Vice Speaker announced that Dr. Cook was unanimously elected.

The Speaker called for nominations for Vice Speaker of the House.

Dr. Donald F. Marion, Dade, nominated Dr. Charles K. Donegan for re-election as Vice Speaker.

Nominations were closed and Dr. Donegan was unanimously elected.

The Speaker called for nominations for Secretary-Treasurer.

Dr. Clyde M. Collins, Duval: "Some 94 years ago a group of physicians, including several from the 21-year-old Duval County Medical Society, got together to organize the Florida Medical Association. They elected officers, and for Secretary-Treasurer they elected Dr. F. P. Wellford of Jacksonville, Florida. A policy that has been in effect for that many years and has been so successful to the organization of this association should not be changed and I would like to renominate Dr. Floyd K. Hurt for the office of Secretary-Treasurer."

Dr. Maurice M. Greenfield, Dade: "Dade County would like to second the nomination of that sterling example of honesty and fiscal integrity, Dr. Floyd Hurt, for Secretary-Treasurer."

Dr. Greenfield then moved that nominations be closed.

The Speaker announced that Dr. Hurt was elected by unanimous ballot.

Dr. Hurt: "I really appreciate this vote of confidence."

Dr. Cook called for the election of three delegates and three alternate delegates to the American Medical Association for two year terms beginning January, 1, 1969 and expiring December 31, 1970.

Dr. H. Phillip Hampton, Hillsborough: "We have inquired and find no other prospective nominees for the delegates and alternate delegates. Hillsborough County Medical Association, however, would like to nominate Dr. Francis C. Coleman to replace Dr. Madison R. Pope as alternate for Dr. Holland. If there is no single objection from the floor, I would like to nominate the whole slate as proposed, and move that nominations be closed."

Motion was carried; the following delegates and alternate delegates were elected:



Drs. Charles J. Collins (left) and Robert E. Zellner escort Mrs. Steward to the rostrum where she is to receive the portrait of Dr. Steward.

Delegate—Reuben B. Chrisman Jr., Coral Gables

Alternate—Samuel M. Day, Jacksonville

Delegate—Francis T. Holland, Tallahassee

Alternate—Francis C. Coleman, Tampa

Delegate—Jere W. Annis, Lakeland

Alternate—Leo M. Wachtel, Jacksonville

There were no additional nominations from the floor, and the Speaker therefore announced the unanimous election of members for the Committee on Membership and Discipline as follows:

District 2:	
Alfred L. Lewis Jr., M.D., Tallahassee	1972
J. Maxey Dell Jr., M.D., Gainesville	1970
District 4:	
Karl T. Humes, M.D., Bushnell	1972
District 6:	
Ernest R. Bourkard, M.D., Tampa	1972
District 8:	
Rowland E. Wood, M.D., St. Petersburg	1972
District 11:	
Nelson Zivitz, M.D., Miami Beach	1972
District 12:	
Rufus K. Broadaway, M.D., Miami	1972

President Steward took the Chair and introduced his family: his wife, Martha; his daughter, Frances and her son, Cullen; his son-in-law, John Bryan; his younger daughter, Martha Dean, and

his son Boyd, as well as his brother-in-law and his wife, Mr. and Mrs. Boyd from Naples.

Dr. Steward then presented his personal gavel to Dr. Jack Q. Cleveland, and said: "It takes a great load off my shoulders to give the mantle of leadership to the man who has been so helpful to me during the past year, knowing that he will live up to everything expected of him. It gives me great pleasure to present this gavel."

Dr. Cleveland: "With deep and sincere appreciation, I accept this office and I can assure you I accept it humbly. It will be hard to follow Dean, since he did a tremendous job. I will really need the help of all the members to have a successful administration.

"I know that some 6,000 members are not always going to agree with the Board of Governors or the House of Delegates, but I will make no major decisions without the help of our governing body."

Dr. Cleveland then introduced his wife, Evelyn, and the other members of his family who were present, Dr. and Mrs. Warren W. Quillian and Mr. Ralph Quillian.

Dr. Cleveland then presented the Past President's lapel button to Dr. Steward.

Dr. Charles J. Collins and Dr. Robert E. Zellner escorted Mrs. Steward to the rostrum and Dr. Cleveland presented to her the portrait of Dr. Steward which had been hung in the Board Room of the FMA office during his term as president.



Dr. Cleveland pins the past president's button on Dr. Steward's coat.



Dr. Cleveland addresses the House after his installation as President.

This was the first time that an oil portrait of the President had been painted, and Mrs. Elsner, who did the portrait, was also recognized.

Mrs. Steward: "It is just beautiful. Those of you who know me well know that I can talk at length on any subject, but today I am speechless on accepting such a beautiful, beautiful portrait of my husband. I am delighted that you elected him to your highest office and I have loved being your president's lady. Thank you very much."

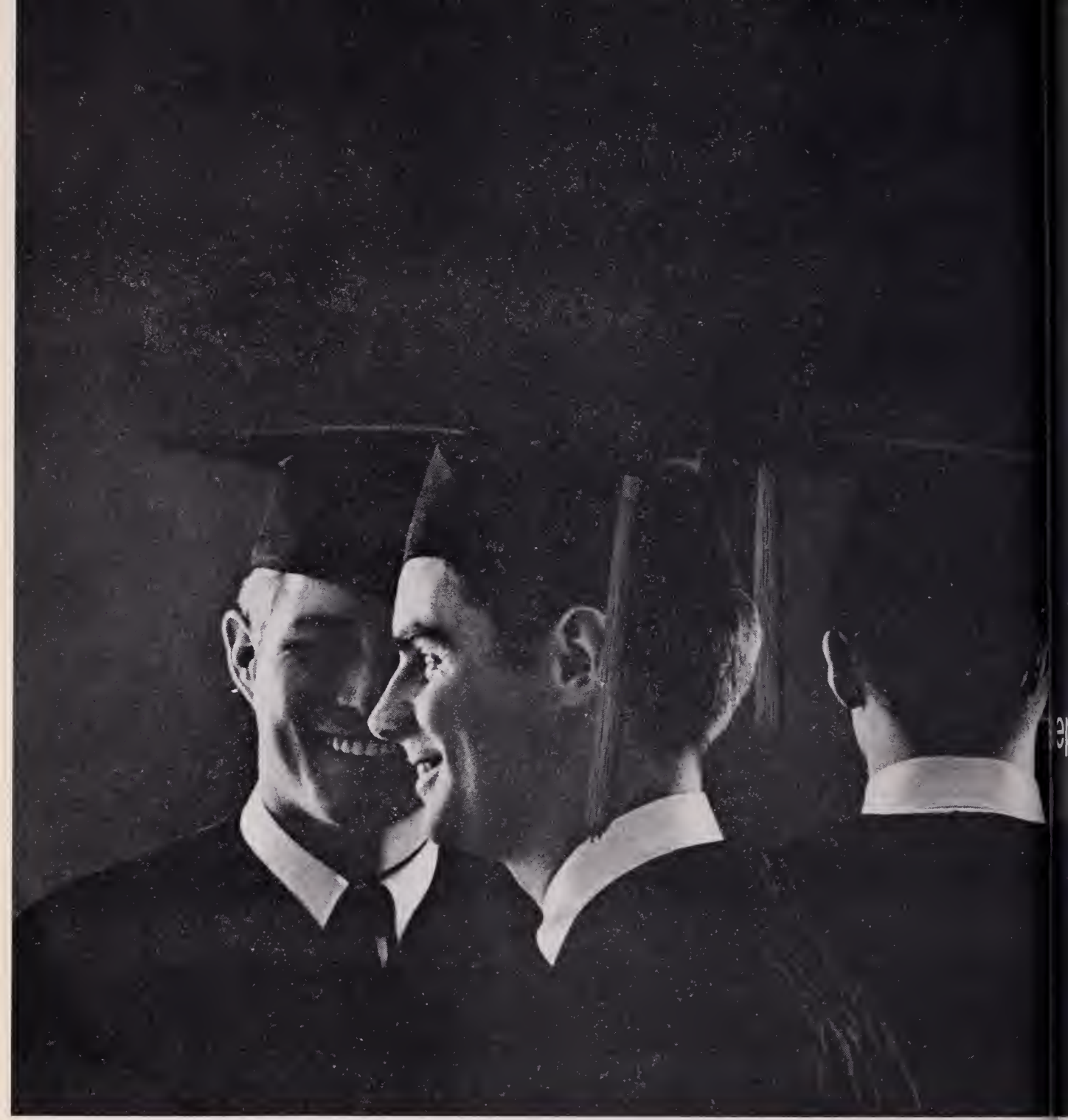
The Speaker announced that immediately following adjournment of the House, the Board of Governors would meet in the Embassy Room.

Dr. Warren Quillian gave the benediction: "Our Heavenly Father, we thank Thee for this meeting, for what it means to all of us, an opportunity for instruction, exchange of ideas and freedom of expression, for fellowship and for the renewal of friendships.

"Help us to rededicate ourselves to the objectives of service to our patients and to our fellow physicians, which are traditional in our great profession. Give us courage, patience and compassion as we return to our daily tasks. May Thy help and wisdom guide those appointed to lead us during the next year. Give them strength and good judgment in the performance of their duties.

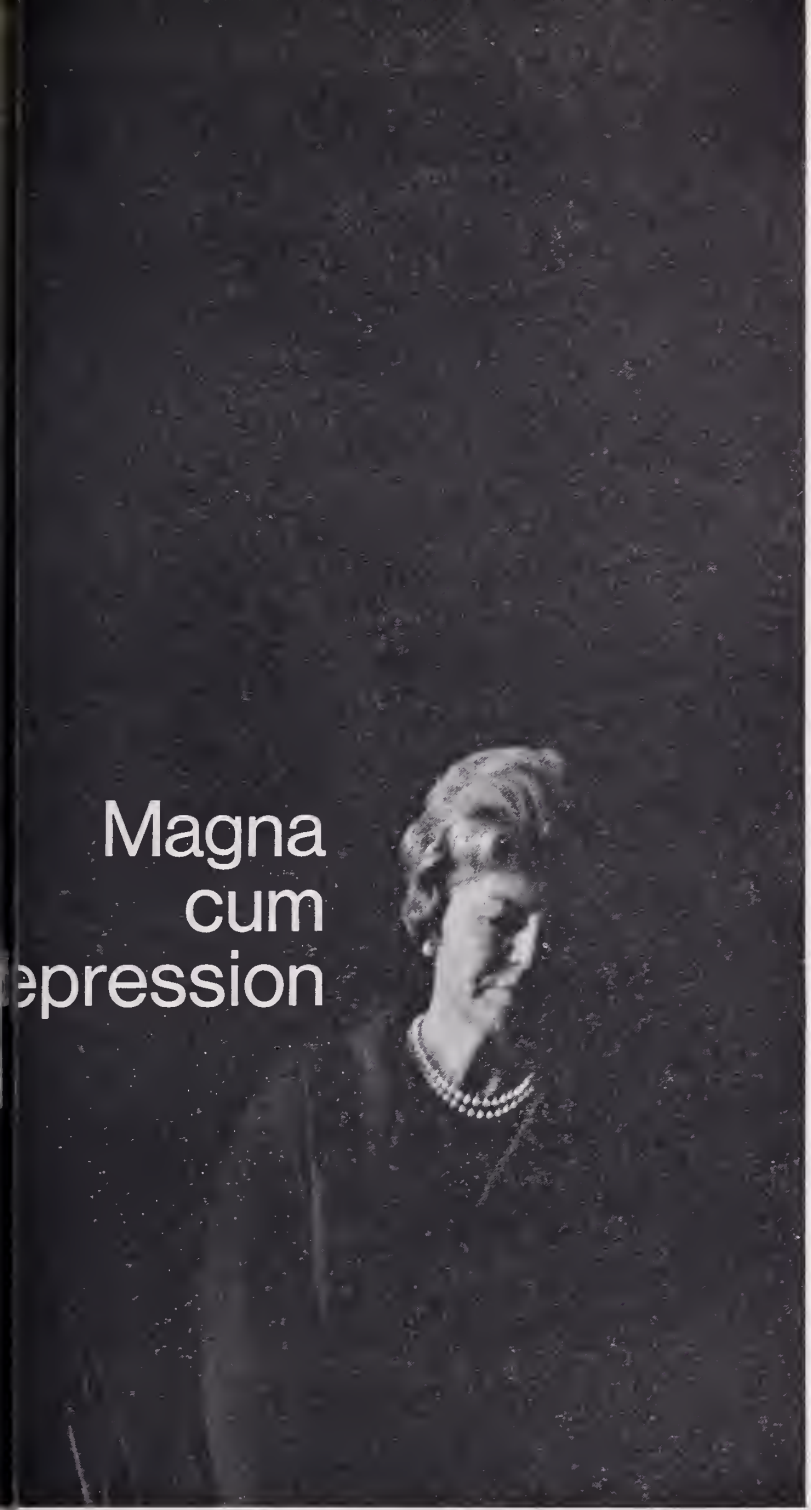
"All of these things we ask in Thy Holy Name. Amen."

Meeting was adjourned at 1:45 p.m.



Tofranil®, imipramine hydrochloride

Indications: Tofranil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes which may require dosage reduction



For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

Tofrānil can often relieve the symptoms of her depression. If it can relieve her mental anguish, you may be able to help her graduate into a new and fruitful life of her own.

Tofrānil could be her commencement, too.

Tofrānil® Geigy
imipramine hydrochloride
in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

addition of a tranquilizer or
rary discontinuation of the drug,
tiform seizures, orthostatic
nsion and substantial blood
re fall in hypertensive patients,
a, transient jaundice, bone mar-
pression including agranulocy-
sensitization and skin rash
ing photosensitization, eosino-
and mild withdrawal symptoms
den discontinuation after pro-
l treatment with high doses.
ional hormonal effects (im-
e, decreased libido, and estro-
effects) may be observed.
ne-like effects may be more
nced (e.g. paralytic ileus) in
tible patients and in those
anticholinergic agents (includ-
tiparkinsonism drugs).
ient Adult Dosage: Initially,
daily, increased, if necessary,
or 200 mg. Maintenance dosage
e lower, 50 to 150 mg. daily, if
le.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Convention Press

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Thomas B. Slade — Fifty Years in Florida — J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 — P. O. Box 2580 — 1050 W. Adams Street — Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Florida Medical editorial

Ninety-Fourth Annual Meeting

Floyd K. Hurt, M.D.

The FMA Annual Meeting of May 1968 by many standards can be considered a resounding success. The Florida Medical Association now has 5,335 active members and of these physicians 1,273 registered for the Annual Meeting. There were 24 specialty group meetings on Saturday and we estimate the total attendance at these meetings was well over 900. There were 25 other related meetings during the conventions. Technical exhibits numbered 74 and there were 20 scientific exhibits; both the scientific and technical exhibits were well attended. Two hundred and thirty delegates were seated at the first meeting of the House of Delegates on Thursday. There is no question that the meetings become larger each year; this means a greater demand for hotel accommodations, which in turn narrows the field to the hotels in the southern part of the state.

Each year the site of the conventions are reviewed by the Board of Governors and so far there have been no other hotel accommodations which were equipped to take care of our annual convention. It is necessary that all of the various meetings and exhibits be in one location.

In spite of the fact that many aspects of the annual meeting are very successful, I am sure that there were many of us who left the second meeting of the House of Delegates with a sense of frustration and disappointment.

Many activities have to be crowded into this last three or four hours at the second meeting of the House of Delegates. The Speakers face a dilemma: they do not wish to cut off discussion and debate on the various reports of the reference committees, yet, on the other hand, everyone agrees that time is of the essence and that there is a limit in going over statements which have already been made before the reference committees. To add to the problem, many hotel rooms must be checked out, cars loaded for departure and rooms made ready for another convention. The election of officers and changing of the Presidents is a function which should not be hurried. I was quite concerned at the second House meeting at the closeness of the vote on at least two motions from a reference committee. It is quite difficult to make a hurried accurate count when delegates tend to move and when some move onto the floor after having left the hall for a brief period of time. We should direct our attention to improving the method of recording the vote. A study should be made on this problem concerning the schedule at the second meeting of the House of Delegates.

The Optimistic Ninety-Fourth

Richard M. Fleming, M.D.

If the 94th Annual Meeting of the Florida Medical Association could be said to have had a theme one would have to call it "Optimism."

President Dean Steward (whose complete address is published elsewhere in this issue) sounded the keynote of the convention with his talk on the future of American medicine. His remarks reflected a great deal of research and thought. He pointed out exciting promises the future holds for medicine and urged that we prepare to participate in the great adventure.

During the opening ceremonies, the president-elect of the Florida Bar, Mr. Marshall Criser, delivered a very fine talk on crime and violence in the streets. The House was so impressed that it passed a resolution endorsing Mr. Criser's recommendations for meeting the situation and instructing delegates to the A.M.A. to introduce a

similar resolution at the annual A.M.A. meeting in June.

Our guest speaker, Dr. Walter Judd, gave a brilliant review of the world scene and our place in this scene. He sounded a note of optimism for our country and profession and urged us to become activists in community and national affairs. He stated this is the only way we can favorably influence the course of events.

Dr. Emerick Szilagyi, a guest speaker of the Florida Association of General Surgeons, delivered what might be called a philosophical essay on the ethics and morals of the practice of medicine. It was reminiscent of Osler's "A Equanimitas" in its perceptiveness—as a matter of fact, it could be called "A Equanimitas Updated." We had hoped to get a copy of this splendid speech so that it could be published in the Journal; unfortunately, the author had promised it to another publication.

Even the "course" in economics, presented by Dr. Arthur Upgren for the Society of Internal Medicine, ended on an optimistic note. He predicted that the economy will continue to grow despite fluctuations and that by the year 2000 the average income in this country would be $21,000.

Both sessions of the House of Delegates proceeded smoothly and on schedule with minimum friction or delay. This was due to our very fine speaker, Jim Cook and vice-speaker, Charles Donegan. Their skillful conduct of the meetings reflected much planning in order to steer our delegates through the channels and to avoid the shoals of parliamentary procedure. Due to the scheduling of our program, however, we seem to encounter each year the problem of running overtime at the second meeting of the House of Delegates. The hotel begins to "breathe down our neck" about noon as they are anxious to get the next crowd in; this puts unnecessary pressure on the delegates.

As our association grows our business will increase in volume and complexity. It might be wise, therefore, to consider a change in our agenda. Actually the only business of the second meeting of the House which must be conducted at this time is action on reference committee reports. Much of the other business might be moved to the first session which could run a little longer. Ultimately we may have to plan for a third meeting of the House of Delegates to handle all of the necessary business.

With reference committees meeting simultaneously one finds it difficult to move from one meeting to another to participate in discussions. Three suggestions may solve this dilemma:



(1) Schedule the reference committee meetings in adjoining rooms (three committees met in adjoining rooms this time and demonstrated how convenient this was for the participants); (2) Have the committee chairmen meet and work out an agenda so that important and controversial resolutions are not discussed simultaneously by committees, and (3) Have pages keep the various rooms informed of the topics being discussed by other committees.

For the first time in my memory we had rain during the President's reception but there was a silver lining, for it pointed up a problem we have sensed for some time. The President's reception is, after all, the sole social function of our Association during the entire year. Does it not deserve to be given more importance? Yes, this would cost more, but I think we can afford one nice function a year where our President can receive his guests in a manner befitting the occasion.

The above minor criticisms notwithstanding, the optimistic 94th will be remembered not only for its favorable predictions but also for the excellence of its sessions and the quality of its speakers. It was well worth the time and effort of everyone who attended. □

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

Diarrhea

TROCINATE® 400 MG.
BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Easy on the Budget... Easy on the Mother

Tablets & Elixir For Iron Deficiency Anemia

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS Fergon®
brand of FERROUS GLUCONATE

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL;
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest HOSPITAL
BIRMINGHAM, ALABAMA

Legal Opinion: Implied Consent Law

The following article is a legal opinion by Mr. Harry Gray, FMA legal counsel, on the Florida Implied Consent Law, Florida Statutes, Section 322.261. According to Mr. Gray, the law is largely copied from the Uniform Chemical Test of Intoxication Act and presents a unique and almost insoluble problem: Can the legislature give implied consent that will protect a physician in an assault and battery suit when the person treated is a minor, incompetent or unconscious due to alcohol or injuries?

Mr. Gray has stated that the opinion herein presented is not as positive as it may be once further information is obtained from various sources.—Ed.

We have studied the legislative act adding sections to Chapter 322, Florida Statutes, which became effective July 1, 1968, and which sections provide for blood tests to be made by a physician when directed by a peace officer.

The Act states that the physician performing the tests shall not be subject to any civil or criminal liability. In the title to the Act and in the body, it is stated that a person gives "implied consent" to the blood test. This presents the legal problem as to the effectiveness of these provisions in relieving a doctor from liability for a suit based on assault and battery for performing a procedure not authorized or consented to. The basic legal principle known to all doctors is simple: A physician who treats or operates upon a patient without having authority to do so commits an assault and battery for which he may be prosecuted criminally or may be held civilly liable. A physician who administers treatment or performs an operation without the patient's consent, expressly or implied, is liable for damages. This legal proposition is stated succinctly in Chambers v. Nottebaum, Court of Appeals, Third District, 96 So2d 716:

> "(1) The rule is well established which prevents a doctor from operating on a patient without his express or implied consent, or in a manner contrary to the patient's express instructions. A statement of this rule was made in Wall v. Brim, 5 Cir., 138 F.2d 478, at page 481:
>
> . . . 'The law is well settled that an operation cannot be performed without the patient's consent and that one performed without consent, express or implied, is a technical battery or trespass for which the operator is liable.' "

This legislative act undertakes to give the consent—the implied consent—of an unconscious person who is injured in a highway account thought by a peace officer to have been the result of alcoholic intoxication. As we have found no decision by any court approving or disapproving this legislation, it is impossible at this time to definitely determine that the statute is valid or is invalid. Until the Appellate Courts of Florida construe this act, only an opinion may be ventured unsupported by judicial authority.

In our opinion, as the statute seeks to deal with a problem relating to injury of citizens on public highways, which injuries have statistically multiplied, the court should look with favor on the legislation seeking to sustain it rather than to reject it because it violates some of the consti-

tutional safeguards in the United States Constitution or the State Constitution.

An analogous situation exists with reference to legislation subjecting a nonresident to suit in Florida when he is injured in an automobile accident on the highways of Florida. Nearly every state, including Florida, has a statute which permits service of legal process to be had upon a nonresident; the procedure usually being based upon "implied consent" from the use of the highway to a suit with service to be made on a state official. The U. S. Supreme Court has upheld such statutes. More recently the trend has been to depart from the doctrine of implied consent and to base the validity of the statutes upon the extent of the activities carried on in the state by the nonresident person involved in the accident. These statutes subjecting nonresidents to suit in the state where the accident occurred, although personal service of process cannot be made, are predicted upon the premise:

> "The increasing slaughter on our highways, most of which should be avoidable, now reaches the astounding figures only heard of on the battlefield."

It is reasonable to suggest that the statute authorizing blood tests should be sustained upon the same predicate—it will aid in the same field as the statute giving implied consent for suit.

It need not be emphasized that if a physician negligently performs a blood test, this will subject him to liability regardless of the validity of the statute now being analyzed.

Physicians are familiar with state legislation in the interest of public health authorizing certain examinations and procedures. Compliance with these statutes by a physician will not subject him to liability, civilly or criminally. Thus it may be urged that the statute we are now considering should be sustained as valid because it fits into the same category.

No physician should make a blood test, relying upon the protection of this statute, unless he establishes that the peace officer has complied with the statute in determining that a blood test is necessary and is authorized. We will not detail these requirements here.

HARRY T. GRAY
MARKS, GRAY, YATES, CONROY & GIBBS
JACKSONVILLE





Comment

Second Annual Benefit Art Show

The July cover shows a statue from the Second Annual Benefit Art Show for physicians and their families held during the 1968 Annual Meeting. We asked Mrs. John R. Hege, the Woman's Auxiliary's art show chairman, to contribute the following comment—Ed.

This year's Benefit Art Show was more than a mere manipulation of tools and color. It was obviously created by artisans who enjoyed what they were doing. There was none of the usual precise drawing technique usually seen in art done by members of the medical profession.

"Spontaneity would be a good key one-word-description of the entire exhibit," said Schubert Jonas, painter, sculptor and member of the art department of the University of Miami. Mr. Jonas was, for eight years, the director of the Fort Lauderdale Museum of Art.

Evidence that medical families have a dynamic interest in human beings was exemplified in their artistic efforts; a sense of motion and interplays of light conveyed a vitality of feeling.

The artists, as well as the viewers were "involved" in the creativity.

Dr. Snow's figure, cast in bronze, of a man in chains was awarded top honor in the sculpture division.

"Excellent composition, good handling of materials . . . Aesthetic qualities, skillfully executed . . . Unusual sensitivity," are phrases the judges used in determining the blue ribbon winner.

Mrs. Edith McGowan, owner of the Schramm Art Galleries in Fort Lauderdale, and Mrs. Jeannette McArthur, supervisor of art for the Broward County Board of Public Instruction, also were judges.

The judges were delighted to see that medical families no longer consider art as a "fringe" activity, but as a worthy expression of ideas disassociated from the tedium of daily chores—a healthy and happy form of relaxation.

Mrs. Thomas C. Kenaston of Rockledge, as state Auxiliary chairman of AMA-ERF in 1966-67, conceived of a Benefit Art Show as a means of spotlighting the work of the Foundation, as well as satisfying a curiosity concerning the rumors that we had many budding artists in the profession.

Florida Medical meetings*

August

15-17 Eighteenth Annual Postgraduate Obstetrics-Pediatric Seminar, FAGP, Desert Inn Motel, Daytona Beach.

September

20-21 Cardiovascular Disease Seminar, AAGP, International Inn, Tampa.

October

29-Nov. 2 Sixth Annual Seminar Congress in Cardiology, Rogers Heart Foundation, Mexico City.

November

1-2 Athletic Injuries Seminar, J. Hillis Miller Health Center, AAGP, Gainesville.

7-9 Today's Hospital Problems: Second Annual Conference, University of Florida and Mound Park Hospital, Tides Hotel and Bath Club, Redington Beach.

*Approved by the FMA Committee on Postgraduate Education.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

8/6135

That many conventioneers came to see this show at the Diplomat more than once is evidence of its success.

We look forward with happy anticipation to the Third Annual Benefit Art Show in 1969.

Mrs. John R. Hege Jr.
Art Show Chairman
Hollywood

Art Show Winners

Best of Show

"Space Medicine Man" by Emmet Ferguson, M. D. and his daughter, Berylin, Jacksonville

Sculpture

1. Bronze Man in Chains (Piece not named) by John Wesley Snow, M.D., Jacksonville
2. "Uncle Phil" (bronze, ¾ life) by W. C. Sumner, M.D., Jacksonville
3. "Inca" (locust wood) by Raymond Fitzpatrick, M.D., Gainesville

Crafts

1. Stoneware Bottle by Mrs. J. W. Pilkington, St. Petersburg
2. Teapot Set by Mrs. J. W. Pilkington
3. Cane Work on child's rocker by Mrs. John Purger, Fort Lauderdale

Painting — Abstract

1. "The City" by Mrs. Daniel de La Penha, Hollywood
2. "Stars In a Frenzy" by Mrs. Raymond d'Adesky, Ormond Beach
3. Oil (Not named) by I. S. Jacobs, M.D., Miami

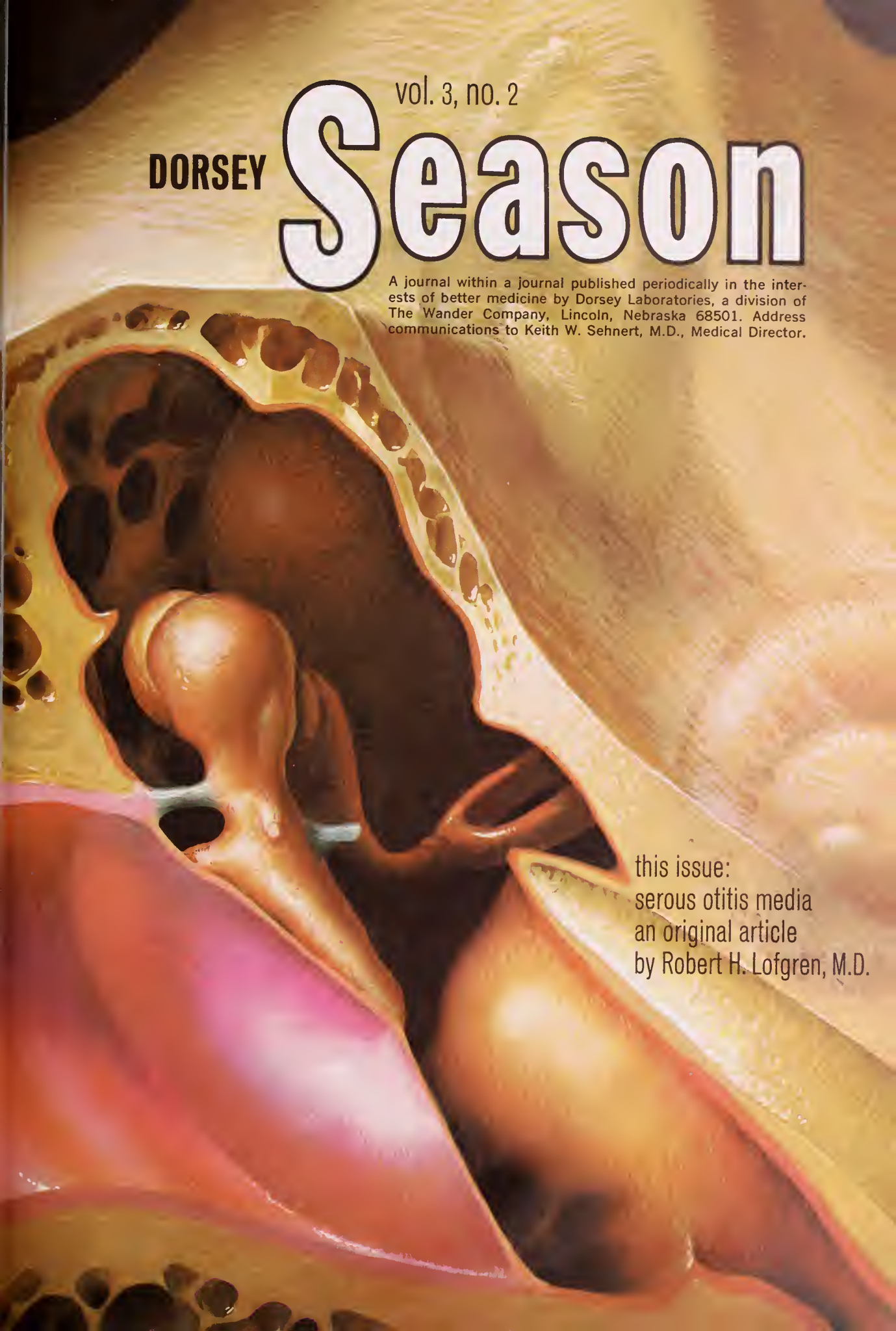
Painting — Representational

1. "Potpourri of Roses" by Mrs. Stanley George Hanna, Miami
2. "Yesterday" by Mrs. John Stage, Jacksonville
3. "Mayport" by Mrs. A. Denton Jones, Jacksonville

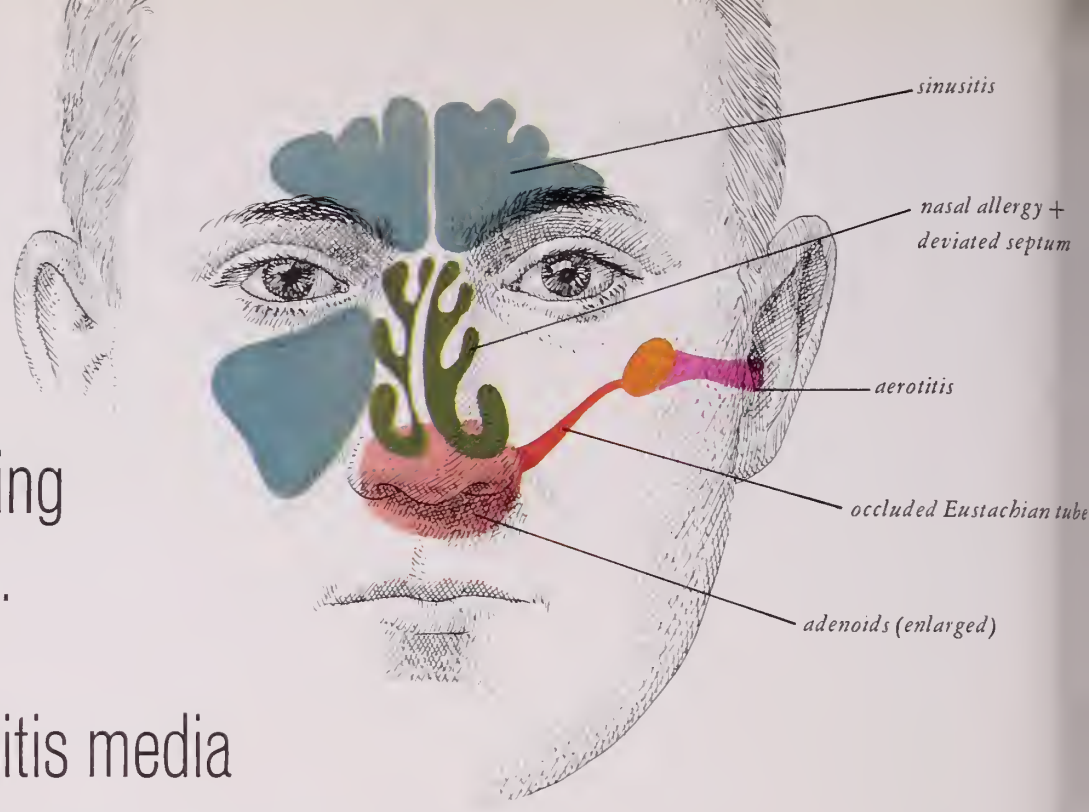
vol. 3, no. 2

DORSEY Season

A journal within a journal published periodically in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.



this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal *Acute Serous* *Acute Purulent* *Chronic Serous*

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

References 1. Senturia, B. H. et al.; Middle Ear Effusions: Pathologic Changes of the Mucoperiosteum in the Experimental Animal, Ann. Otol. 71:632-648, 1962. 2. Grahne, B.; Serous Otitis Media, Acta Oto-Laryng. 58:1-8, 1964. 3. Sade, J.; Pathology and Pathogenesis of Serous Otitis Media, Arch. Otolaryng, 84:297-305, 1966. 4. Buckingham, R. A. and Ferrer, J. L.; Reversibility of Chronic Adhesive Otitis Media with Polyethylene Tubes, Laryngoscope 76:993-1014, 1966. 5. Chalat, N. I. and Lounsbury, E.; A Hearing Phenomenon and Serous Otitis, Laryngoscope 76:983-992, 1966. 6. Shucknecht, H. F.; Chronic Otitis Media in Children: A New Treatment, Clin. Pediat. 3:718-727, 1964. 7. Feuerstein, S. S.; Surgery in Serous Otitis Media, Laryngoscope 76:686-708, 1966. 8. Kapur, Y. P.; Serous Otitis Media in Children, Arch. Otolaryng. 79:38-48, 1964. 9. Silverstein, H., Miller, G. F., Jr. and Lindemman, R. C.; Eustachian Tube Dysfunction as a Cause for Chronic Secretory Otitis in Children, Laryngoscope 76:259-273, 1966.



You can relieve his congestion and sniffles and her concern with

"The Orange Medicine"

You know it as Triaminic Syrup, but mothers of kids with colds and allergies know it as the orange-colored, good-tasting medicine that makes life a lot more livable at either end of the teaspoon. Triaminic Syrup contains not one, but two antihistamines, plus an effective oral nasal decongestant. This balanced formulation has promptly and effectively relieved nasal congestion for so many.

TRIAMINIC® SYRUP

Each teaspoonful (5 ml.) contains: phenylpropanolamine hydrochloride 12.5 mg.; pheniramine maleate 6.25 mg.; pyrilamine maleate 6.25 mg. Side effects: Drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis. Dosage: Children 1-6, ½ tsp.; Children 6-12, 1 tsp.; Adults, 2 tsp. Administer every 4 hours. Supplied: Bottles of 4 fl. oz., pints.

(Advertisement)

Florida Medical | feature

The Physician's Place in Public Affairs

Walter H. Judd, M.D.

It is always a unique personal pleasure to meet with members of the profession in which I spent 26 years of my life—as a student and as a physician. During those years, I enjoyed the deep and abiding satisfactions that always come to one when he knows he is helping persons in need.

Another reason I treasure your invitation is because of the deep respect I have for this, my own profession. Years of scientific disciplines and daily experience with naked human beings under stress or in pain—persons as they really are—have given most physicians:

Habits of thought—cool heads;

Attitudes toward people—warm hearts;

The capacity to make decisions—courage;

The capacity to carry through—even greater courage.

These are precisely the qualities the nation so sorely needs in its leaders today—and so seldom finds.

No one can question the high quality of the scientific knowledge and technical skills of our profession. If there is reason for concern, it is more likely to be with respect to the quality of our citizenship; for that must be of a higher order than we frequently have had in our country in recent years or there may not long be a society in which we will have opportunity to use with success and satisfaction the knowledge and skills we all worked so long and hard to acquire.

Physicians, by training and tradition, are prepared to accept and use the veritable explosions in scientific knowledge of the last few decades. Physicians generally are not prepared, either by tradition or training, for the explosions in the socio-economic fabric of our society.

Physicians have been accustomed to a wholly private and intimate doctor-patient relationship with no intervention by any third party. Their chief concern has been with the *quality* of their services. Problems of distribution of medical care were minimal; today they are monumental—and the government is playing the dominant role.

So physicians must play a more active role in public affairs for at least three reasons:

First, to insure our future as professional men and women; to safeguard the conditions under which we can use to best advantage our knowledge of disease and abnormalities and our skills in helping those who need our assistance.

Secondly, in order to work toward betterment of environmental conditions that affect adversely our patients. The man who comes with a stubborn arthritis or dermatitis or duodenal ulcer or hypertension or vague chest pain or insomnia frequently has something else bothering him, too. Perhaps he has a boy in Vietnam, or his business is in difficulty, or inflation has eaten up more than half of his life savings, or he is apprehensive about nuclear war. He knows his country is in deep trouble. He has legitimate and serious anxieties. If we are really to help him with his whole medical problem, we must pay more attention to the impact on him of both his national and his world environment, and try to influence that environment in the direction of making it more favorable to his well-being. We are not doing our medical duty to our patients unless we make maximum effort in this field.

Thirdly, we must play a larger role in public affairs in order to insure our future as human

Presented at the General Session (Abel S. Baldwin Lecture) of the 94th Annual Meeting of the Florida Medical Association, May 9-12, 1968, Hollywood.

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amb suppresses appetite and helps offset en tional reactions to dieting. **Contraindi tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advanc renal or hepatic disease. **Precautions:** Administer with c tion in the presence of cardiovascular disease or hypertensi **Side Effects:** Nervousness or excitement occasionally not but usually infrequent at recommended dosages. Slight dro iness has been reported rarely. See package insert for furt details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBIN

beings. All of us are custodians of a great and noble heritage of freedom, a political and economic order which made it possible for even those of us who come from humblest circumstances to get the expensive education which we could scarcely have dreamed of in most parts of the world. That heritage of freedom is gravely endangered both by determined assault from without and by ignorance, apathy and indifference within.

What we know as doctors about the practice of medicine should and must influence our thinking and activities as citizens. But our obligation as citizens must also influence our thinking and conduct as doctors.

We talk much about what effect our government's actions may have upon us. We must give more thought to what effect we can and should have on our government.

For example, who else can so well understand, and contribute so much to helping other citizens understand, the malignant nature of the Communist process which in 50 years has spread its blight over one-third of the world and threatens the remainder, including our own free America? If we fail here, we fail everywhere.

For there is on this planet a malignant conspiracy dedicated to our destruction. The thing that makes a cancer bad is not its size or its location; it is the lawless way it grows. In practically all respects, the Communist movement behaves like other malignancies. It has rejected the normal processes of growth, it never stops where it begins and it expands by lawlessly encroaching on tissues that do not belong to it. Sometimes that encroachment is by direct invasion of an adjacent organ—or an adjoining country like Korea, Hungary, Tibet or Laos. Or it extends more stealthily by metastases—transplants of malignant cells lodging and working within other organs, or within other countries (like South Vietnam, Thailand, Greece, Venezuela, U.S.A.), to disrupt their economy, subvert their thinking and weaken their institutions in preparation for takeover.

To deal successfully with the present malignant threat to our survival, how urgently our country needs the kind of mind which his training has given the physician.

First, the autopsy type of mind. You have been trained to study your mistakes and write about them openly in your journals in order for all to learn from them. We do autopsies not to cover up, but to correct. In government, the prevailing rule is not to correct, but to cover up. Each of the concessions we have made to the Soviet Union since World War I without firm insistence on substantial concessions, not just conciliatory words, in return, has led to losses for freedom. Yet how many people in America today, without your kind of mind, are urging our government to trust again the same old patterns that the autopsy shows have always failed.

We also need in public affairs more men with the biopsy type of mind. When you look through a microscope and see some abnormal cells, "revolutionists," that have broken through the basement membrane in violation of normal laws of growth, you don't say, "Well, it's cancer all right, but let's wait and see if it spreads." You *know* it will spread unless you find ways to stop it at once and where it is. But during the last four decades, how many among our people in America have said, "Isn't it too bad what Hitler is doing to the Jews, or the Japanese militarists are doing to the Chinese, or the Russian Communists are doing to the Hungarians, and perhaps soon to the Czechs, or the North Vietnamese Communists are doing to the South Vietnamese. But, after all, those places are a long way off. Surely it isn't our job to help police other parts of the world. Let's see if we can't persuade the malignant elements to confine their efforts to the areas presently involved, and not spread to us." But could Hitler be malignant to the Jews and benign toward us? Can Communism be malignant to others, Tibetans, Vietnamese, Cubans, East Germans, and benign toward us?

The medically trained person knows that in dealing with a cancer there can be no end to the struggle until it or the body prevails. This means that, as a minimum, we have to isolate it by cutting off its blood supply and the lymph channels by which it transmits its lawless cells to other areas. Likewise, we must prevent the Communist cancer from gaining access to new areas, such as expanded trade or diplomatic recognition would give Red China, or admission into the United Nations before it qualifies for membership by abandoning its lawless conduct, that is, its malignant character.

While fighting the malignant process, we know that also we must build up the strength and health of the rest of the organism, the parts not involved—the resistance of the countries and peoples that are still free.

We have been taught that almost the only forgivable mistake for us to make is to underestimate the possible seriousness of a patient's

condition. If we overestimate it we are guilty of nothing but some undue caution; but if we underestimate it, the patient may die. The mistake is unforgivable because it is irretrievable.

Likewise, in the world struggle between lawless and law-abiding forces, it would be an unforgivable mistake to fail to understand the cancerous character of the Communist new growth—or to underestimate its strength, its determination, the dangerous inroads which it has already made into the organs of our Nation and the thinking of our people, without their realizing it. We must not make that mistake ourselves and it is our duty as citizens not to let our fellow citizens make it. For it could be fatal.

We can't outwait it; we must outwork and outwit it.

It is equally essential that we not make the mistake of underestimating the strength of our own philosophy and faith—the basic soundness of the American system and its attraction and appeal to the oppressed millions of the earth.

What the world generally *wants* most from the United States is our wealth, our goods, our tools. But these are not what it *needs* most—for these are all results. What the world needs most from us is the secret that led to those results.

The secret is an economic system which provides maximum opportunity and incentive for men to get ahead, to create, to produce, to expand, in order to improve their lives.

That economic system came from a political philosophy—the right of the individual citizen.

That political philosophy in turn came from a religious faith—the belief that there is a Creator, and that every man is endowed by his Creator—not by his government—with certain inalienable rights arising from his importance and worth as a child of God. Our government was established to protect those rights, not to take them away.

Perhaps our most urgent task is to reexamine more thoughtfully what is the essence of the American philosophy of life—and the faith out of which it grew.

For what main purpose did our forefathers originally come to this country? To establish a government that would look after them? No, they came here to get a chance to look after themselves. Are we now to feel embarrassed or apologetic because under the system they established they were successful?

In essence, the struggle, both here and all around the world, is between those who believe

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

in government-from-the-top-down and those who believe in government-from-the-bottom-up.

Confronted with a tough problem, one side goes to the central government *first;* the other goes to the central government *last*—that is, only if and when their own efforts and all local remedies have been exhausted.

One believes that because some federal government is necessary, *more* government must be better. The other remembers that the history of man's struggle for liberty is the history of his struggle to hold down, not expand, the powers of government.

One believes that because a national government must intervene in emergencies—wars, earthquakes, floods, depressions, civil disorders—therefore it should take over more and more management of people's lives all the time, including those times when there are no emergencies.

One believes that speed in solving a problem is in direct proportion to the amount of money the government puts into it (which, of course, it can do only with money it has taken from you; there is no other source). Others believe that almost always a more serious bottleneck than lack of funds is lack of trained and dedicated personnel.

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS since 1932 PM ©

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

A Modern Psychiatric Hospital . . .



This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

One believes that because a good government should provide a floor below which no citizen is allowed to fall in lack of food, housing, education, medical care: therefore it should provide a bed on which all citizens are invited to recline without further need to struggle.

One believes that government should provide equal rewards to its citizens: the other believes the first function of a good government is to provide equal opportunities for its citizens—not because it does not want the fullest possible rewards for all, but just because it does want such rewards, and believes this is the best way to get them.

Some, because of their preoccupation with those who are inadequate or unfortunate—and there will always be such—become so concerned with helping these that they think this is the first function of a good society. Others, equally sincere, believe that the more we care about the poor, the more the primary effort of our government must be to provide maximum opportunity and incentive for the many to become solvent— for only as the many become solvent and self-supporting can there be resources with which to help the unfortunate.

One believes the primary role of our national government, in the carefully chosen words of our forefathers, is to "*promote* the general welfare." Others believe the government can and should "provide" it.

In summary, what kind of government is best? That which does most for people directly or that which makes it possible for most people to do most for themselves, and then assists—generously, fully—those who for whatever reason cannot or do not provide properly for themselves and their families?

I think it can be stated as a law that whenever a government does for its citizens that which they have the capacity to do for themselves, it begins to weaken, rather than strengthen, the foundations of freedom and the means of progress.

These larger issues are decided in the political arena, and nowhere else. It is hard to justify any physician's thinking he is too busy to work at government—which means at politics—for politics determines government—and government today determines the conditions of our lives as well as of our practice.

Therefore, join the political party you think is nearest right on the most important issues, work in and through it to select, and then to elect,

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

good men and women to public office at every level of government. You can never get anyone who is everybody's first choice. Frequently the only way to avoid one's last choice is to work and vote for one's second or third choice!

Don't imagine you can do much after election to change the votes of a Congressman or Senator who owes his election to those opposed to your views. Your job is to elect and reelect persons who already hold the same general views as you. They will want to vote for them out of conviction; and with your support they can do so without committing political suicide, something not too many in any walk of life choose to do.

One more requirement. More professional persons must become willing to be candidates for public office. Both patriotism and good sense require that *all* citizens, no matter how specialized their training, be willing to sacrifice their careers to go into public office as a public service, just as many are called to sacrifice their careers for a time, and perhaps their lives, to go into the armed forces as a public service.

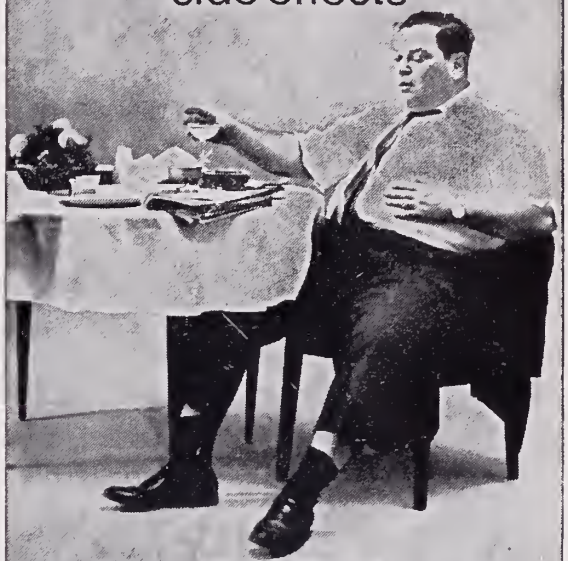
Only as we *do* these things—not just discuss them, but act—will there be hope. The most wonderful thing about our country, the thing which we must strive at all cost to preserve, is the privilege we still have of changing the things we think are wrong. Wherever conditions are bad, or don't meet our standards, we *can* correct them *—if we will work in politics.*

The way to begin is with ideas and principles, get persons and parties committed to them, translate them into programs and put them into practice.

Please do not think I am trying to lecture you today, or that I am suggesting that the profession as a whole has not been awake to these problems. On the contrary, it has made tremendous efforts, including here in Florida, and I congratulate you. Rather, I am appealing to you to do still more. This "patient"—our country—is too sick to be saved without the intelligent leadership of men and women with the qualities of mind and heart of the good physician—the cool head and the warm heart, the capacity to decide and the courage to carry through.

It is hard work—but freedom is worth it. □

In Obesity, anorectic action with fewer unwanted side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m.
Appetite control at 6
Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

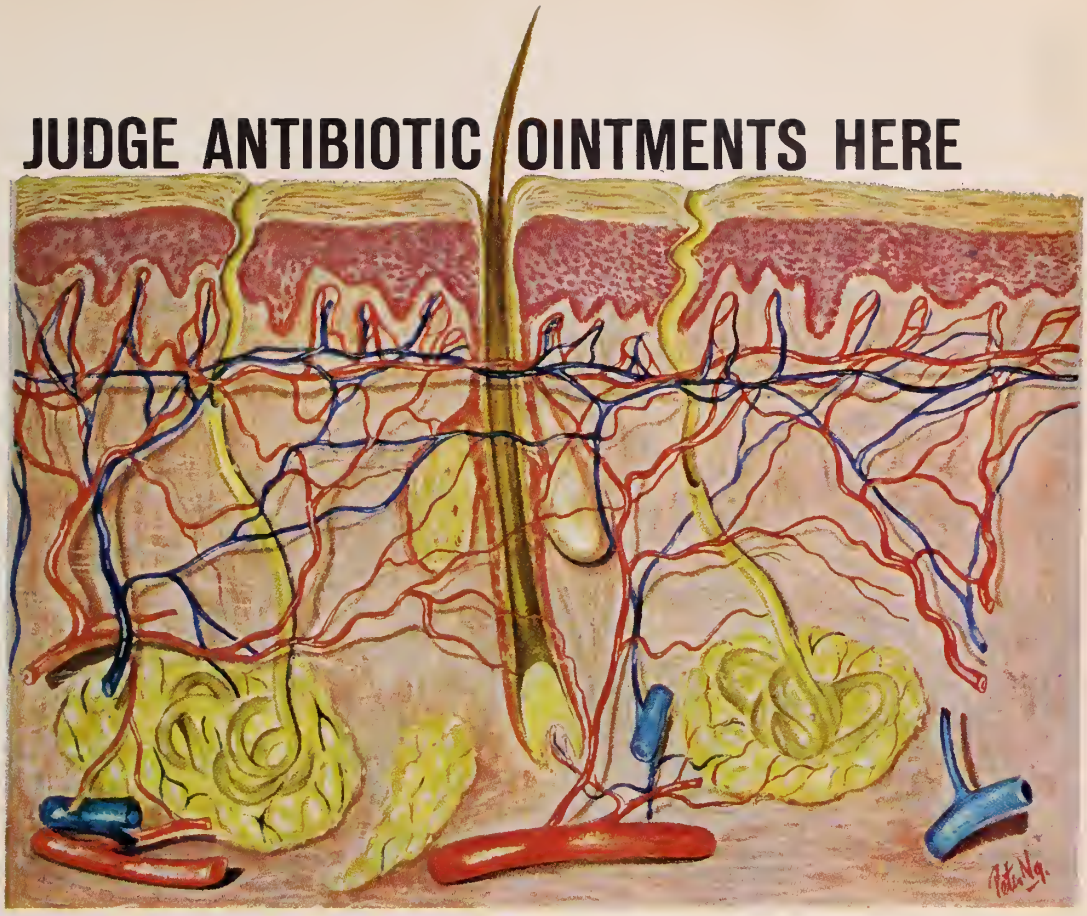
For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S.J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	William C. Evans Jr., Gainesville	George A. Dell, Gainesville	2nd Tues.	46	144
Bay **Bradford, Gilchrist, Union*	Tim M. Smith, Panama City	Harry C. Alfred, Panama City	1st Tues.	0	42
Brevard	Ben C. Storey, Titusville	Leon H. Osman, Titusville	2nd Tues.	13	151
Broward	Russell B. Carson, Ft. Lauderdale	Robert J. Brennan, Ft. Lauderdale	4th Tues.	58	439
Charlotte	Charles M. Wilson, Port Charlotte	Francis R. Meyers, Punta Gorda	2nd Tues.	0	13
Clay	Arthur D. Thaeler Jr., Penney Farms	E. Charlton Prather, Orange Park	4th Tues.	0	15
Collier	Ethel H. Trygstad, Naples	Lucian L. Alexander, Naples	3rd Wed.	1	30
Columbia	Charles T. Ozaki, Lake City	Don D. Weiffenbach, Lake City	3rd Wed.	0	14
Dade	Maurice M. Greenfield, Miami	Vincent P. Corso, Miami	1st Tues.	223	1,466
DeSoto-Hardee-Glades	Harold S. Agnew, Arcadia	Gordon H. McSwain, Arcadia	1st Tues.	1	17
Duval	Clyde M. Collins, Jacksonville	John A. Rush Jr., Jacksonville	1st Tues.	37	440
Escambia	William T. Patton, Pensacola	Theodore J. Marshall, Pensacola	2nd Tues.	4	135
Franklin-Gulf	J. Wayne Hendrix, Port St. Joe	Photis J. Nichols, Apalachicola	Last Wed.	1	5
Gadsden-Liberty	James E. Thompson, Chattahoochee	Taylor W. Griffin, Quincy	Quarterly	1	14
Highlands	Francis M. Swain, Sebring	Helen M. Williams, Avon Park	3rd Mon.	3	23
Hillsborough	Henry L. Wright, Tampa	Rodney D. Steinmetz, Tampa	1st Tues.	8	344
Indian River	Hampton L. Schofield Jr., Vero Beach	John H. Terry, Vero Beach	2nd Tues.	4	25
Jackson-Calhoun	William F. Brunner, Marianna	Glenn E. Padgett, Marianna	1st Thurs.	0	17
Lake	C. Robert Crow, Mount Dora	Thomas H. Nichols, Clermont	1st Wed.	1	47
Lee-Hendry	Peter Bercaw, Fort Myers	Wallace M. Graves Jr., Fort Myers	3rd Mon.	9	72
Leon-Wakulla-Jefferson	Alfred L. Lewis Jr., Tallahassee	George N. Lewis, Tallahassee	1st Mon.	9	87
Madison	A. Franklin Harrison, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	0	6
Manatee	Millard P. Quillian, Bradenton	Robert E. King, Bradenton	2nd Tues.	4	61
Marion **Levy*	William C. Butscher Jr., Ocala	C. Brooks Henderson, Ocala	3rd Tues.	6	46
Monroe	Jose T. Sanchez Jr., Key West	Jaime M. Benavides Jr., Key West	1st Thurs.	2	24
Nassau **Baker*	Cecil B. Brewton, Fernandina Beach	John B. Britton, Fernandina Beach	2nd Thurs.	3	7
Okaloosa	Robert J. Saxer, Fort Walton Beach	Joseph C. Wilson, Fort Walton Beach	1st Wed.	0	26
Orange **Osceola*	Louis C. Murray, Orlando	Paul C. Harding, Orlando	3rd Wed.	48	341
Palm Beach	James R. Forlaw, Boynton Beach	Robert R. Wadlund, Delray Beach	4th Mon.	38	292
Pasco-Hernando-Citrus **Sumter*	Warren A. Clark, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	1	31
Pinellas	Jack A. MaCris, St. Petersburg	Joseph A. Ezzo, St. Petersburg	1st Mon.	73	402
Polk	George P. Graf, Winter Haven	Marvin G. Burdette, Winter Haven	2nd Wed.	18	191
Putnam	Larry G. Hebel, Palatka	Charles E. Barrineau, Palatka	2nd Tues.	2	12
St. Johns	Kenneth J. Farrow, St. Augustine	Vernon A. Lockwood, St. Augustine	3rd Tues.	0	20
St. Lucie-Okeechobee-Martin	George Theodorou, Fort Pierce	Robert P. Dimmett, Fort Pierce	3rd Thurs.	3	47
Santa Rosa	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	2nd Tues.	2	12
Sarasota	Leo H. Wilson Jr., Sarasota	William E. DesPortes, Sarasota	2nd Tues.	10	127
Seminole	William C. Rape, Sanford	Robert J. Smith, Sanford	2nd Tues.	0	28
Suwannee-Hamilton-LaFayette	Frederick T. Mickler Jr., Jasper	Alex Kish, Live Oak	1st Sat.	0	7
Taylor **Dixie*	Hoyt Horne, Perry	John A. Dyal Jr., Perry	Last Fri.	0	8
Volusia **Flagler*	William E. Carter, DeLand	Richard W. Dodd, Daytona Beach	2nd Tues.	10	127
Walton	Edgar H. Myers, DeFuniak Springs	McKinley Cheshire Jr., DeFuniak Spgs.	3rd Tues.	0	8
			Total	640	5,366
			Grand Total	6,006	
			Direct	1	3

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.

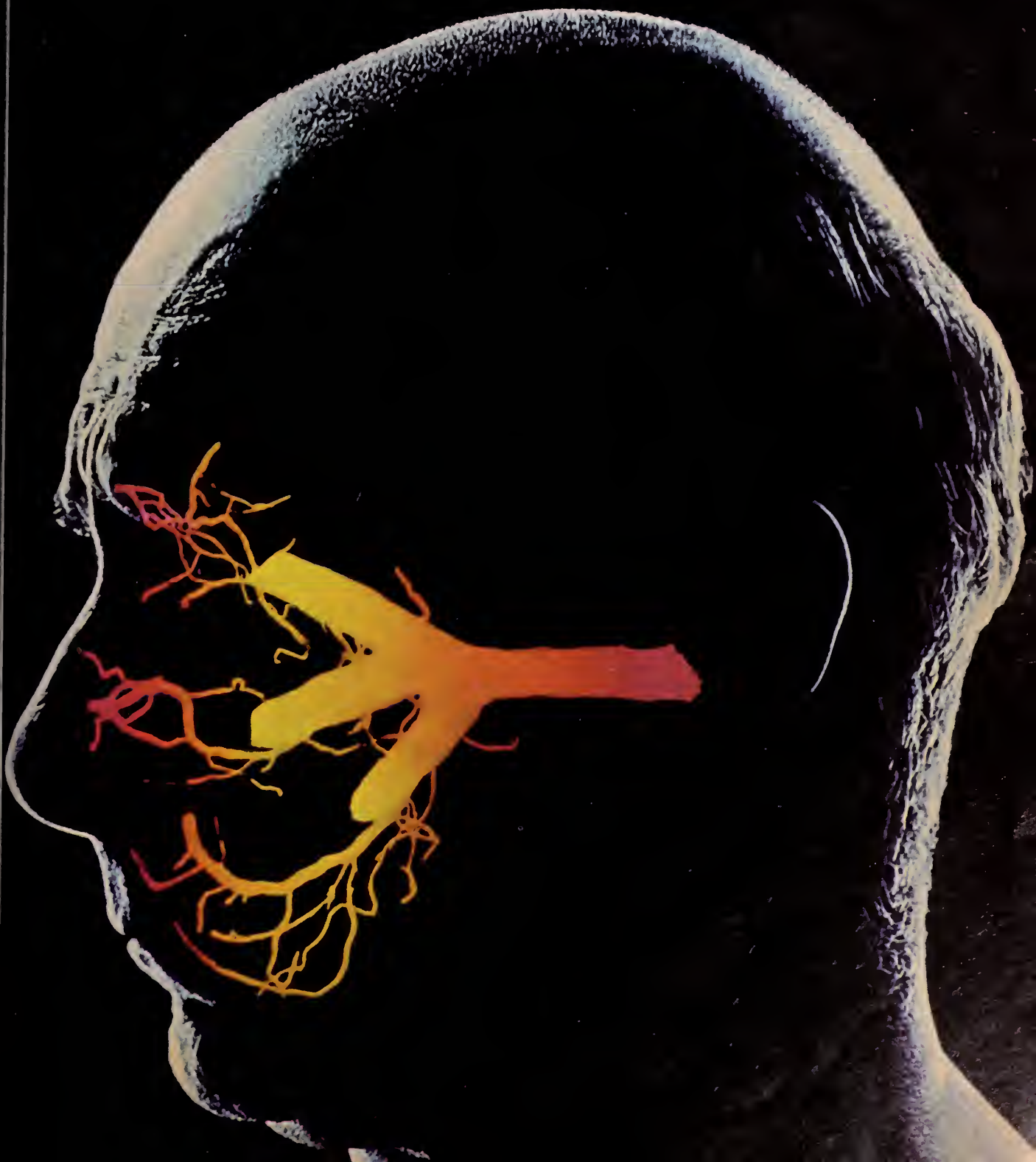
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of uncommon pain





A little

Just one 50 or 100 mg.
tablet in the morning can
work a long diuretic day
in edema and hypertensi

HY-6113



lygroton® can work a long day too

lorthalidone

at's because of its prolonged ion, usually providing smooth uretic activity throughout the day. d one-a-day dosage, in the g run, means few tablets to take d few tablets to pay for.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton

chlorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of smoll bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients ond in potients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemio, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R2-46-230-D

For full details, please see the complete prescribing information.

Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Florida Medical Association
Officers, Councils and Committees
1968-1969

OFFICERS

JACK Q. CLEVELAND, M.D., President ....Coral Gables
HENRY J. BABERS JR., M.D.,
President-Elect ....Gainesville
IRVING E. HALL JR., M.D., Vice President ...Bradenton
JAMES T. COOK, M.D.,
Speaker of the House ....Marianna
CHARLES K. DONEGAN, M.D.,
Vice Speaker ....St. Petersburg
FLOYD K. HURT, M.D.,
Secretary-Treasurer ....Jacksonville
W. DEAN STEWARD, M.D.,
Immediate Past President ....Orlando

EXECUTIVE DIRECTOR

W. HAROLD PARHAM ....Jacksonville

BOARD OF GOVERNORS

JACK Q. CLEVELAND, M.D.,
*Chm., Ex Officio ....Coral Gables
HENRY J. BABERS JR., M.D.*
(President-Elect) Ex Officio ....Gainesville
IRVING E. HALL JR., M.D.
(Vice President) Ex Officio ....Bradenton
JAMES T. COOK, M.D.
(Speaker of the House) Ex Officio ....Marianna
FLOYD K. HURT, M.D.*
(Secretary-Treasurer) Ex Officio ....Jacksonville
GEORGE S. PALMER, M.D. + PP-69 ....Tallahassee
W. DEAN STEWARD, M.D.*... PP-70 ....Orlando
JACK A. MaCRIS, M.D. AL-69 ....St. Petersburg
WILLIAM M. C. WILHOIT, M.D.*....A-70 ....Pensacola
WILLIAM J. DEAN, M.D.... B-71 ....St. Petersburg
CHARLES R. SIAS, M.D.... C-69 ....Orlando
RICHARD M. FLEMING, M.D. D-72 ....Miami Beach
REUBEN B. CHRISMAN JR., M.D.
AMA delegate-69 ....Coral Gables
EUGENE G. PEEK JR., M.D.... SBH-69 ....Ocala

Executive Committee
+Public Relations Officer

Subcommittees:

Inter-American Relations
DAVID A. OHLWILER, M.D., Chm. ....*Winter Park*
WILLIAM P. CLARKE, M.D., Vice Chm. ..*Jacksonville*
JOHN J. FISHER, M.D. ....*Jacksonville*
LOUIS P. BRADY, M.D. ....*Orlando*
JACOB R. ROZIER, M.D. ....*Winter Park*
RICHARD P. SCHMIDT, M.D. ....*Gainesville*
WILSON T. SOWDER, M.D. ....*Jacksonville*

Quackery
MILLARD P. QUILLIAN, M.D., Chm. ....*Bradenton*
WILLIAM A. MULFORD, M.D. ...*Green Cove Springs*
JOHN H. MICKLEY, M.D. ....*Hollywood*
COLLIN F. BAKER JR., M.D. ....*Tampa*
M. EUGENE FLIPSE, M.D. ....*Coral Gables*

Venomous Snake Bite
CARL E. ANDREWS, M.D., Chm. ....*West Palm Beach*
RAY O. EDWARDS JR., M.D. ....*Jacksonville*
KENNETH W. JACKSON, M.D. ....*Lake Alfred*
JOHN E. DEES, M.D. ....*Miami*
L. WASHINGTON DOWLEN, M.D. ....*Miami*

COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS

JAMES W. WALKER, M.D., Chm. ....*Jacksonville*

DENTISTRY

WILLIAM M. DOUGLAS, M.D., Chm...C-71 ....*Orlando*
GROVER W. AUSTIN, M.D...AL-69 ....*St. Petersburg*
W. ROY HANCOCK, M.D. .. A-72 ....*Jacksonville*
ARGIN A. BOGGUS, M.D. .. B-70 ....*Tavares*
JAMES G. ROBERTSON, M.D. .. D-69 ....*Miami*

LAW

HILBERT A. P. LEININGER, M.D.,
Chm. .. D-71 ....*Coral Gables*
AMOS L. PREVATT, M.D. .. AL-69 ....*Pensacola*
GERALD D. N. BRYANT, M.D. .. A-70 ....*Tallahassee*
JAMES R. BOULWARE JR., M.D. .. B-69 ....*Lakeland*
CARROLL M. CROUCH, M.D. .. C-72 ....*Daytona Beach*

MEDICAL ASSISTANTS

WOODS A. HOWARD, M.D., Chm. .. AL-69 ....*Lakeland*
SAMUEL J. ALFORD, M.D. .. A-71 ....*Jacksonville*
JAMES M. STEM, M.D. .. B-70 ....*Clearwater*
FRED H. ALBEE JR., M.D. .. C-69....*Daytona Beach*
LEON H. MIMS JR., M.D. .. D-72 ....*Coral Gables*

MEDICAL TECHNOLOGISTS

MILLARD B. WHITE, M.D., Chm. .. B-71 ....*Sarasota*
LAUDIE E. McHENRY JR., M.D. .. AL-69 ..*Melbourne Beach*
SANFORD A. MULLEN, M.D. .. A-70 ....*Jacksonville*
HAMPTON L. SCHOFIELD JR., M.D. .. C-69 ..*Vero Beach*
M. EUGENE FLIPSE, M.D...D-72 ....*Coral Gables*

NURSING

JAMES W. WALKER, M.D., Chm. .. A-72 ....*Jacksonville*
CHARLES H. GILLILAND, M.D. .. AL-69 ....*Gainesville*
JOHN M. BUTCHER, M.D...B-69 ....*Sarasota*
THOMAS C. KENASTON JR., M.D. .. C-71 ....*Cocoa*
JAMES J. HUTSON, M.D. .. D-70 ....*Miami*

PHARMACY

BEN C. STOREY, M.D., Chm. .. C-71 ....*Titusville*
THOMAS D. WEAVER, M.D. .. AL-69 ....*Clermont*
GRETCHEN V. SQUIRES, M.D. .. A-72 ....*Pensacola*
JOSEPH A. EZZO, M.D. .. B-69 ....*St. Petersburg*
M. JAY FLIPSE, M.D. .. D-70 ....*Miami*

PHYSICAL THERAPY AND REHABILITATION THERAPISTS

WILLIAM J. HUTCHISON, M.D.,
Chm...AL-69 ....*Tallahassee*
JOSEPH C. SHIPP, M.D. ..A-72 ....*Gainesville*
ARTHUR J. PASACH, M.D. .. B-69 ....*Tampa*
LOUIS J. NOVAK, M.D. .. C-70 ....*Hollywood*
STERLING H. HUNTINGTON, M.D. .. D-71 ..*Coral Gables*

RELIGION

SAMUEL F. SMITH JR., M.D., Chm. .. B-70 ....*Tampa*
GRETCHEN V. SQUIRES, M.D. .. A-69 ....*Pensacola*
WILLIAM A. VAN NORTWICK, M.D. .. AL-69 *Jacksonville*
CURTIS D. BENTON JR., M.D. .. C-71 ....*Ft. Lauderdale*
ALBERT C. JASLOW, M.D. .. D-72 ....*South Miami*

VETERINARY MEDICINE

HIRAM C. POLK JR., M.D., Chm. .. D-71 ....*Miami*
JOHN H. PARKER JR., M.D. .. AL-69 ....*Perry*
GEORGE W. KARELAS, M.D. .. A-70 ....*Newberry*
IRWIN S. LEINBACH, M.D. .. B-69 ....*St. Petersburg*
JAMES C. RINAMAN, M.D. .. C-72 ....*St. Cloud*

RADIOLOGIC AND NUCLEAR MEDICINE TECHNOLOGISTS

EDWARD C. BURNS JR., M.D., Chm. .. AL-69 ..*Lake Wales*
ALEXANDER GOULARD JR., M.D...A-69 ....*Ocala*
RALPH C. AYE, M.D...B-72 ....*Tampa*
HERBERT D. KERMAN, M.D. .. C-70 ....*Daytona Beach*
WILLIAM J. WINTER JR., M.D. .. D-71 ....*Miami*

JUDICIAL COUNCIL

JOHN J. CHELEDEN, M.D., Chm. ....*Daytona Beach*

ARCHIVES

WILLIAM M. STRAIGHT, M.D., Chm. .. D-70 ....*Miami*
J. RAYMOND GRAVES, M.D. .. AL-69 ....*Miami*
JOSEPH P. HENDRIX, M.D. .. A-71 ....*Port St. Joe*
W. WARDLAW JONES, M.D. .. B-69 ....*Dade City*
HUGH WEST, M.D. .. C-72 ....*DeLand*

GRIEVANCE

WARREN W. QUILLIAN, M.D., Chm. ....*Coral Gables*
SAMUEL M. DAY, M.D. ....*Jacksonville*
H. PHILLIP HAMPTON, M.D. ....*Tampa*
GEORGE S. PALMER, M.D. ....*Tallahassee*
W. DEAN STEWARD, M.D. ....*Orlando*

MEDICAL LICENSURE

J. CHAMPNEYS TAYLOR, M.D., Chm. ..... *Jacksonville*
MADISON R. POPE, M.D. ..... *Plant City*
SCHEFFEL H. WRIGHT, M.D. ..... *Miami*

MEMBERSHIP AND DISCIPLINE

District 1 —WILLIAM C. ROBERTS, M.D. .. 71 *Panama City*
JAMES T. COOK, M.D., Chm ..69 .. *Marianna*
District 2 —ALFRED L. LEWIS JR., M.D. .. 72 *Tallahassee*
J. MAXEY DELL JR., M.D. .. 70 ...*Gainesville*
District 3 —THOMAS M. IRWIN, M.D...70 ....*Jacksonville*
HUGH A. CARITHERS, M.D. .. 71 ..*Jacksonville*
District 4 —JOHN J. CHELEDEN, M.D. .. 70 .....*Daytona*
KARL T. HUMES, M.D...72 .....*Bushnell*
District 5 —THOMAS C. KENASTON SR., M.D. .. 69 *Cocoa*
FRANK C. BONE, M.D. .. 71 .....*Orlando*
District 6 —ERNEST R. BOURKARD, M.D. .. 72 ....*Tampa*
C. FRANK CHUNN, M.D. .. 69 .....*Tampa*
District 7 —GORDON H. McSWAIN, M.D. .. 71 ....*Arcadia*
JOHN M. BUTCHER, M.D. .. 70 .....*Sarasota*
District 8 —EDWARD L. COLE JR., M.D. .. 69 *St. Petersburg*
ROWLAND E. WOOD, M.D. .. 72 *St. Petersburg*
District 9 —WILLIAM H. PROCTOR, M.D. .. 70
West Palm Beach
MYRL SPIVEY, M.D. .. 71 ...*West Palm Beach*
District 10—MILES J. BIELEK, M.D...71 ...*Ft. Lauderdale*
RUSSELL B. CARSON, M.D...69.*Ft. Lauderdale*
District 11—HAROLD RAND, M.D. .. 70 .....*Miami*
NELSON ZIVITZ, M.D. .. 72 ....*Miami Beach*
District 12—RUFUS K. BROADAWAY, M.D...72 ....*Miami*
JACK Q. CLEVELAND, M.D. .. 69 *Corol Gables*

COUNCIL MEMBER FROM BOARD OF PAST PRESIDENTS

GEORGE S. PALMER, M.D. ..... *Tallahassee*

COUNCIL ON LEGISLATION AND PUBLIC AGENCIES

JERE W. ANNIS, M.D., Chm. ..... *Lakeland*

STATE LEGISLATION

EDWARD G. HASKELL JR., M.D., Chm. .. A-70 *Tallahassee*
THOMAS M. QUEHL, M.D. .. AL-69 .....*St. Petersburg*
JOHN E. OREBAUGH, M.D. .. B-71 .....*St. Petersburg*
LOUIS C. MURRAY, M.D. .. C-69 .....*Orlando*
JOSEPH H. DAVIS, M.D. .. D-72 .....*Miami*

Subcommittee—Liaison with State Agencies:

FRANCIS T. HOLLAND, M.D. Chm. .....*Tallahassee*
SIMON D. DOFF, M.D. Commission on Aging ....*Jacksonville*
PAUL S. JARRETT, M.D., Alcoholic Rehabilitation ....*Miami*
EUGENE G. PEEK JR., M.D., Board of Health .....*Ocala*
MARION W. HESTER, M.D., Council for the Blind *Lakeland*
LOUIS P. BRADY, M.D., Crippled Children's Commission .....*Orlando*
RAYMOND J. FITZPATRICK, M.D., Division of Correction .....*Gainesville*
WILLIAM C. RUFFIN JR., M.D., Division of Mental Health .....*Gainesville*
WESLEY S. NOCK, M.D., Education Department *Coral Gables*
THOMAS J. BIXLER, M.D., Industrial Commission *Tallahassee*
ARTHUR W. WOOD JR., M.D., Insurance Department .....*Miami*
JERE W. ANNIS, M.D., Public Welfare .....*Lakeland*
LAWRENCE E. GEESLIN, M.D., Tuberculosis Board .....*Jacksonville*
WILLIAM H. EVERTS, M.D., Vocational Rehabilitation .....*West Palm Beach*
CORNELIA M. CARITHERS, M.D., Divisions of Youth Services and Mental Retardation .....*Jacksonville*

NATIONAL LEGISLATION

JOSEPH C. VON THRON, M.D., Chm. .....*Cocoa Beach*
JERE W. ANNIS, M.D. .....*Lakelond*
H. PHILLIP HAMPTON, M.D. .....*Tampa*
PHILIP B. PHILLIPS, M.D. .....*Pensocola*
EDWARD G. HASKELL JR., M.D. .....*Tallahassee*
SAMUEL M. DAY, M.D. .....*Jacksonville*
EUGENE G. PEEK JR., M.D. .....*Ocala*
CHARLES R. SIAS, M.D. .....*Orlando*
ROBERT W. WITHERS, M.D. .....*Tompo*
MELVIN M. SIMMONS, M.D. .....*Sarasoto*
ALLYN B. GIFFIN, M.D. .....*St. Petersburg*
CARL E. ANDREWS, M.D. .....*West Palm Beach*
ANDRE S. CAPI, M.D. .....*Ft. Louderdale*
JACK Q. CLEVELAND, M.D. .....*Corol Gables*
RICHARD M. FLEMING, M.D. .....*Miami Beoch*

Subcommittee—Liaison with Federal Agencies:

ROY E. CAMPBELL, M.D., Chm. .....*Palatka*
JERE W. ANNIS, M.D., Department of Health, Education and Welfare .....*Lakelond*
ROBERT H. MICKLER, M.D., Department of Justice .....*Tollohassee*
THOMAS J. BIXLER, M.D., Department of Labor .....*Tollahassee*
ROY E. CAMPBELL, M.D., Veterans Administration ..*Palatka*

COUNCIL ON MEDICAL ECONOMICS

JACK A. MaCRIS, M.D., Chm. .....*St. Petersburg*

ADVISORY TO BLUE SHIELD AND FISCAL INTERMEDIARIES

JOHN C. FLETCHER, M.D., Chm...B-70 .....*Tampa*
JAMES L. BORLAND JR., M.D...AL-69 .....*Jacksonville*
EDSON J. ANDREWS, M.D...A-69 .....*Tallahassee*
RAYMOND J. FITZPATRICK, M.D...A-70 .....*Gainesville*
ALFRED L. LEWIS, M.D...A-71 .....*Tallahassee*
JOHN A. RUSH JR., M.D...A-72 .....*Jacksonville*
RALPH C. AYE, M.D...B-69 .....*Tampa*
HENRY G. MORTON, M.D...B-71 .....*Sarasota*
IRVING M. ESSRIG, M.D...B-72 .....*Tampa*
JACK T. BECHTEL, M.D...C-69 .....*Indialantic*
JOHN R. MAHONEY, M.D...C-70 .....*Ft. Lauderdale*
THOMAS F. RAYMOND, M.D...C-71 ....*West Palm Beach*
FREDERICK C. ANDREWS, M.D...C-72 .....*Mount Dora*
FREDERICK B. ZAUGG, M.D...D-69 .....*Coral Gables*
RICHARD C. CLAY, M.D...D-70 .....*Miami*
JAMES L. ANDERSON, M.D...D-71 .....*Miami*
RICHARD F. STOVER, M.D...D-72 .....*Coral Gables*

HEALTH INSURANCE

ARTHUR W. WOOD JR., M.D., Chm. .. AL-69 .....*Miami*
BILLY BRASHEAR, M.D. .. A-72 .....*Gainesville*
GEORGE H. WELCH JR., M.D. .. B-71 .....*St. Petersburg*
ARTHUR L. EBERLY, M.D. .. C-70 .....*Pompano Beach*
CHARLES A. MONNIN JR., M.D. .. D-69 .....*Miami*

HOSPITALS AND EXTENDED CARE FACILITIES

VERNON B. ASTLER, M.D., Chm. .. AL-69 ..*Boynton Beoch*
JOSEPH L. RUBEL, M.D...A-69 .....*Pensacola*
EDWARD W. SALKO, M.D...B-71 .....*Fort Myers*
ALBERT F. STRATTON JR., M.D. .. C-72 .....*Cocoa*
ROBERT F. DICKEY, M.D. .. D-70 .....*Miami*

MEMBERS INSURANCE

RICHARD A. WORSHAM, M.D., Chm. .. A-72 ..*Jacksonville*
H. LAWRENCE SMITH, M.D. .. AL-69 .....*Tallahassee*
WILLIS W. HARRIS, M.D. .. B-71 .....*Bradenton*
RUSSELL D. D. HOOVER, M.D. .. C-69 ..*West Palm Beach*
H. CLINTON DAVIS, M.D. .. D-70 .....*Miami*

RELATIVE VALUE STUDIES

FRED A. BUTLER, M.D., Chm. .. B-71 .....*Naples*
STUART C. SMITH, M.D. .. AL-69 .....*Tallohossee*
JAMES A. CRANFORD JR., M.D. .. A-69 .....*Jacksonville*
EMMET F. FERGUSON JR., M.D...A-70 .....*Jacksonville*
CHARLES K. DONEGAN, M.D. .. B-70 .....*St. Petersburg*
WILLIAM E. HOFFMEISTER, M.D. .. C-71 ..*Winter Park*
JOSEPH G. MATTHEWS, M.D. .. C-72 .....*Orlondo*
FRANKLIN J. EVANS, M.D. .. D-69 .....*Coral Gables*
HUMBERTO M. NOGUEIRAS, M.D. .. D-72 .....*Miami*

COUNCIL ON MEDICAL SERVICES

JAMES M. INGRAM, M.D., Chm. .....*Tampa*

AGING

SIMON D. DOFF, M.D., Chm. .. AL-69 .....*Jacksonville*
CHARLES J. KAHN, M.D. .. A-70 .....*Pensacola*
WILLIAM H. HUBBARD, M.D. .. B-69 ...*New Port Richey*
CLARENCE M. GILBERT, M.D...C-72 .....*Orlando*
CHARLES R. BEBER, M.D...D-71 .....*Miomi*

BLOOD

FAIRFAX E. MONTAGUE, M.D., Chm..AL-69 .....*Palatka*
GERARD H. HILBERT, M.D...A-70 .....*Pensacolo*
LEO E. REILLY, M.D...B-69 .....*St. Petersburg*
FREEMAN H. CARY, M.D...C-71 .....*Orlando*
MAXWELL M. SAYET, M.D...D-72 .....*Miami Beach*

CHILD HEALTH

WESLEY S. NOCK, M.D., Chm...D-70 .....*Coral Gables*
WARREN W. QUILLIAN II, M.D...AL-69 .....*Coral Gables*
THOMAS M. BRILL, M.D...A-69 .....*Goinesville*
THOMAS M. WILEY JR., M.D...B-72 .....*Ft. Myers*
IRWIN T. TAYLOR, M.D...C-71 .....*Winter Pork*

EMERGENCY MEDICAL SERVICE

JAMES L. CAMPBELL JR., M.D., Chm...C-69 .....*Orlondo*
WILLIAM C. ROBERTS, M.D...AL-69 .....*Ponamo City*
SAM C. ATKINSON, M.D...A-69 .....*Jacksonville*
JOHN M. BUTCHER, M.D...B-69 .....*Sorasota*
FRANK M. WOODS, M.D...D-69 .....*Miomi*

HEARING

GEORGE T. SINGLETON, M.D., Chm...AL-69 ...*Gainesville*
WILLIAM F. SHIPMAN JR., M.D...A-70 .....*Tallahassee*
THOMAS M. EDWARDS, M.D...B-69 .....*Tampa*
JOHN H. WEBB JR., M.D...C-72 .....*Orlondo*
JAMES R. CHANDLER JR., M.D...D-71 .....*Miami*

LABOR

LAURENT P. LaROCHE, M.D., Chm...AL-69 ...*Cocoa Beach*
ALBERT E. McQUAGGE, M.D...A-72 .....*Marianna*
JAMES B. HODGE JR., M.D...B-71 .....*Tampa*
THEODORE J. KAMINSKI, M.D...C-70 .....*Melbourne*
JAMES J. HUTSON, M.D...D-69 .....*Miami*

MATERNAL HEALTH

FRANK M. PARISH, M.D., Chm...AL-69 .....*Orlando*
JAMES P. McNEIL, M.D...A-70 .....*Jacksonville*
T. VERNON FINCH, M.D...B-72 .....*Sarasota*
GROVER C. McDANIEL JR., M.D...C-69 ....*Ft. Lauderdale*
GUILLERMO A. PUENTE-DUANY, M.D...D-71 ....*Miami*
Consultants: William T. Mixson, M.D. .....*Coral Gables*
Charles L. Lippoldt, M.D. .....*Orlando*
Frank C. Bone, M.D. .....*Orlando*
William A. Little, M.D. .....*Miami*
John D. Milton, M.D. .....*Coral Gables*
Harry Prystowsky, M.D. .....*Gainesville*

MENTAL HEALTH

WILLIAM C. RUFFIN JR., M.D., Chm...AL-69 ..*Gainesville*
MERTON L. EKWALL, M.D...A-70 .....*Tallahassee*
ZACK RUSS JR., M.D...B-69 .....*Tampa*
JAMES W. ETTINGER, M.D...C-72 .....*Rockledge*
JAMES R. JUDE, M.D...D-71 .....*Miami*

MENTAL RETARDATION

CORNELIA M. CARITHERS, M.D.,
Chm...AL-69 .....*Jacksonville*
CHARLES R. BENTON, M.D...A-70 .....*Pensacola*
RAY C. WUNDERLICH JR., M.D...B-71 .....*St. Petersburg*
W. AMBROSE McGEE, M.D...C-72 .....*West Palm Beach*
HERMAN SELINSKY, M.D...D-69 .....*Miami Beach*

OCCUPATIONAL HEALTH

THOMAS B. THAMES, M.D., Chm...C-72 .....*Orlando*
LAURENT P. LaROCHE, M.D...AL-69 .....*Cocoa Beach*
SAMUEL S. LOMBARDO, M.D...A-69 .....*Jacksonville*
CHARLES LARSEN JR., M.D...B-70 .....*Lakeland*
JAMES J. HUTSON, M.D...D-71 .....*Miami*

PUBLIC HEALTH

CLARENCE L. BRUMBACK, M.D.,
Chm...C-72 .....*West Palm Beach*
WILLIAM R. STINGER, M.D...AL-69 .....*Miami*
JOHN B. BRITTON, M.D...A-69 .....*Fernandina Beach*
ALBERT B. McCREARY, M.D...B-71 .....*St. Petersburg*
JOHN D. MILTON, M.D...D-70 .....*Coral Gables*

RURAL HEALTH

JOSEPH W. LAWRENCE, M.D., Chm...B-71 ....*Ft. Myers*
LAWRENCE G. HEBEL, M.D...AL-69 .....*Palatka*
GEORGE W. KARELAS, M.D...A-72 .....*Newberry*
J. BASIL HALL, M.D...C-70 .....*Tavares*
RALPH E. CROSS, M.D...D-69 .....*Homestead*

VISION

WILLIAM H. ANDERSON JR., M.D., Chm...A-71 ....*Ocala*
G. BROCK MAGRUDER, M.D...AL-69 .....*Orlando*
JOSEPH W. TAYLOR JR., M.D...B-70 .....*Tampa*
CURTIS D. BENTON JR., M.D...C-69 .....*Ft. Lauderdale*
DAVID W. SIME, M.D...D-72 .....*Miami*

COUNCIL ON SCIENTIFIC ACTIVITIES

RICHARD C. DEVER, M.D., Chm. .....*Miami*

THE JOURNAL AND OTHER PUBLICATIONS

FRANZ H. STEWART, M.D., Editor .....*Miami*
CLYDE M. COLLINS, M.D., Assistant Editor ....*Jacksonville*
OSCAR W. FREEMAN, M.D., Assistant Editor .....*Orlando*
RICHARD M. FLEMING, M.D., Assistant Editor
from the Board of Governors .....*Miami Beach*

MEDICAL SCHOOLS

HENRY J. BABERS JR., M.D., Chm...A-71, Alachua
County Medical Society .....*Gainesville*
RAYMOND J. FITZPATRICK, M.D...AL-69 ....*Gainesville*
SORRELL L. WOLFSON, M.D...B-69, Hillsborough
County Medical Association .....*Tampa*
CECIL G. BUTT, M.D...C-72 .....*Orlando*
EDWARD W. CULLIPHER, M.D...D-70, Dade
County Medical Association .....*Miami*
W. DEAN WARREN, M.D., Faculty, Univ. of Miami ..*Miami*
SAMUEL P. MARTIN, M.D., Faculty,
University of Florida .....*Gainesville*
ALFRED H. LAWTON, M.D., Faculty,
University of South Florida .....*Tampa*

POSTGRADUATE EDUCATION

RICHARD G. CONNAR, M.D., Chm...B-70 .....*Tampa*
MATTHEW E. MORROW JR., M.D...AL-69 ....*Jacksonville*
JAMES J. DeVITO, M.D...A-71 .....*St. Augustine*
CHARLES J. COLLINS, M.D...C-69 .....*Orlando*
MAURICE M. GREENFIELD, M.D...D-72 .....*Miami*

RESEARCH

DONALD W. SMITH, M.D., Chm...AL .....*Jacksonville*
KARL B. HANSON, M.D...A .....*Jacksonville*
MILLARD B. WHITE, M.D...B .....*Sarasota*
MARTIN G. GOULD, M.D...C .....*Ft. Pierce*
JAMES J. GRIFFITTS, M.D...D .....*Miami*

SCIENTIFIC ASSEMBLIES

EDWIN T. LONG, M.D., Chm...B-71 .....*Lakeland*
DONALD F. MARION, M.D...AL-69 .....*Miami*
GEROLD L. SCHIEBLER, M.D...A-72 .....*Gainesville*
RUSSELL B. CARSON, M.D...C-69 .....*Ft. Lauderdale*
JEROME H. MODELL, M.D...D-70 .....*Miami*

COUNCIL ON SPECIAL ACTIVITIES

WILLIAM C. ROBERTS, M.D., Chm. .....*Panama City*

ADVISORY TO WOMAN'S AUXILIARY

LINUS W. HEWIT, M.D., Chm...AL-69 .....*Tampa*
GORDON H. IRA, M.D...A-71 .....*Jacksonville*
EUGENE B. MAXWELL, M.D...B-69 .....*Tampa*
LEE ROGERS JR., M.D...C-72 .....*Rockledge*
PERRY D. MELVIN, M.D...D-70 .....*Miami*

BOARD OF PAST PRESIDENTS

FRANCIS H. LANGLEY, M.D., Chm...1956 ..*St. Petersburg*
W. DEAN STEWARD, M.D., Secy...1967 .....*Orlando*
WILLIAM M. ROWLETT, M.D...1933 .....*Tampa*
ORION O. FEASTER, M.D...1936 .....*Long Bch., Miss.*
EDWARD JELKS, M.D...1937 .....*Jacksonville*
WALTER C. JONES, M.D...1941 .....*Miami*
EUGENE G. PEEK SR., M.D...1943 .....*Ocala*
WILLIAM C. THOMAS SR., M.D...1945 .....*Gainesville*
JOSEPH S. STEWART, M.D...1948 .....*Miami*
WALTER C. PAYNE SR., M.D...1949 .....*Pensacola*
ROBERT B. McIVER, M.D...1952 .....*Jacksonville*
FREDERICK K. HERPEL, M.D...1953 ..*Laguna Hills, Calif.*
DUNCAN T. McEWAN, M.D...1954 .....*Orlando*
JOHN D. MILTON, M.D...1955 .....*Coral Gables*
WILLIAM C. ROBERTS, M.D...1957 .....*Panama City*
JERE W. ANNIS, M.D...1958 .....*Lakeland*
RALPH W. JACK, M.D...1959 .....*Miami*
LEO M. WACHTEL, M.D...1960 .....*Jacksonville*
ROBERT E. ZELLNER, M.D...1962 .....*Orlando*
WARREN W. QUILLIAN, M.D...1963 .....*Coral Gables*
SAMUEL M. DAY, M.D...1964 .....*Jacksonville*
H. PHILLIP HAMPTON, M.D...1965 .....*Tampa*
GEORGE S. PALMER, M.D...1966 .....*Tallahassee*
W. DEAN STEWARD, M.D...1967 .....*Orlando*

A.M.A. HOUSE OF DELEGATES

ROBERT E. ZELLNER, M.D.—Delegate .....*Orlando*
RALPH W. JACK, M.D.—Alternate .....*Miami*
(terms expire Dec. 31, 1969)
BURNS A. DOBBINS JR., M.D.—Delegate ...*Ft. Lauderdale*
WALTER E. MURPHREE, M.D.—Alternate .....*Gainesville*
(terms expire Dec. 31, 1969)
REUBEN B. CHRISMAN JR., M.D.—Delegate ..*Coral Gables*
SAMUEL M. DAY, M.D.—Alternate .....*Jacksonville*
(terms expire Dec. 31, 1968)
FRANCIS T. HOLLAND, M.D.—Delegate .....*Tallahassee*
MADISON R. POPE, M.D.—Alternate .....*Plant City*
(terms expire Dec. 31, 1968)
JERE W. ANNIS, M.D.—Delegate .....*Lakeland*
LEO M. WACHTEL, M.D.—Alternate .....*Jacksonville*
(terms expire Dec. 31, 1968)

COUNCIL ON SPECIALTY MEDICINE

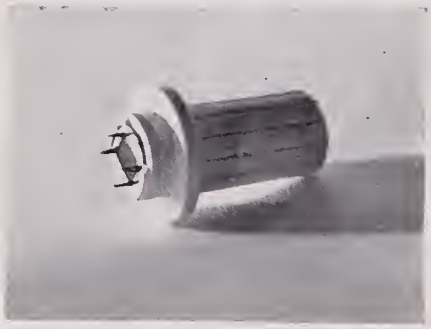
JOSEPH G. MATTHEWS, M.D., Chm. .....*Orlando*

COMMITTEES

ANESTHESIOLOGY—
JAMES D. BEESON, M.D...1971 .....*Jacksonville*
DERMATOLOGY—
JACK H. BOWEN, M.D...1971 .....*Jacksonville*
GENERAL PRACTICE—
WALTER W. SACKETT JR., M.D...1969 .....*Miami*
INTERNAL MEDICINE—
ROBERT E. RABORN, M.D...1972 .....*Delray Beach*
NEUROSURGERY—
EDWARD J. SULLIVAN JR., M.D...1970 ....*Jacksonville*
OBSTETRICS & GYNECOLOGY—
CURTIS G. REBECK, M.D...1969 .....*Tampa*

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/61

OPHTHALMOLOGY—
JAMES W. CLOWER JR., M.D...1969 .....*Daytona Beach*
OTOLARYNGOLOGY—
WEST BITZER, M.D...1970 .....*Ocala*
ORTHOPEDICS—
JOSEPH G. MATTHEWS, M.D...1971 .....*Orlando*
PATHOLOGY—
SANFORD A. MULLEN, M.D...1972 .....*Jacksonville*
PEDIATRICS—
RICHARD G. SKINNER JR., M.D...1972 .....*Jacksonville*
PLASTIC SURGERY—
BERNARD L. N. MORGAN, M.D...1969 .....*Jacksonville*
PSYCHIATRY—
SAMUEL G. HIBBS, M.D.—1971 .....*Tampa*
RADIOLOGY—
ANDRE S. CAPI, M.D...1972 .....*Ft. Lauderdale*
SURGERY—
EMMET F. FERGUSON JR., M.D...1970 .....*Jacksonville*
UROLOGY—
DAVID W. GODDARD, M.D...1970 .....*Daytona Beach*

Subcommittee on Specialty Groups:

MEYER B. MARKS, M.D.,
Florida Allergy Society .....*Miami Beach*
GEORGE T. EDWARDS, M.D.,
Florida Society of Anesthesiologists .....*Ft. Lauderdale*

Florida Chapter, American College of Chest Physicians
ARNOLD R. GODDARD, M.D.,
Florida Society of Dermatology .....*Miami*
JAMES H. JOHNSON, M.D.,
Florida Gastroenterologic Society .....*Lakeland*
WILLIAM P. CLARKE, M.D.,
Florida Academy of General Practice .....*Jacksonville*
ROBERT L. ANDREAE, M.D.,
Florida Society of Internal Medicine .....*Jacksonville*
JAMES B. PERRY, M.D.,
Florida Society of Neurology .....*Ft. Lauderdale*
HOWARD C. CHANDLER, M.D.,
Florida Neurosurgical Society .....*Jacksonville*
JOSEPH W. PILKINGTON, M.D.,
Florida Obstetrics & Gynecologic Society .....*St. Petersburg*
CHARLES F. MCCRORY, M.D.,
Florida Society of Ophthalmology .....*Jacksonville*
ALBERT A. WILSON, M.D.,
Florida Orthopedic Society .....*Tampa*
JAMES H. MENDEL JR., M.D.,
Florida Society of Otolaryngology .....*South Miami*
WALLACE M. GRAVES JR., M.D.,
Florida Society of Pathologists .....*Ft. Myers*
THOMAS M. BRILL, M.D.,
Florida Pediatric Society .....*Gainesville*
JUSTINE L. VAUGHEN, M.D.,
Florida Society of Physical Medicine and Rehabilitation .....*Orlando*
WILLIAM G. TAYLOR, M.D.,
Florida Society of Plastic & Reconstructive Surgery .....*Tampa*
JAMES A. HORTON, M.D.,
Florida Society of Preventive Medicine .....*Okeechobee*
MANUEL L. CARBONELL, M.D.,
Florida Proctologic Society .....*Miami*
WALTER M. WHITE JR., M.D.,
Florida Psychiatric Society .....*St. Petersburg*
WADE RIZK, M.D.,
Florida Radiological Society .....*Jacksonville*
HARRY W. REINSTINE JR., M.D.,
Florida Chapter, American College of Surgeons .....*Jacksonville*
CLYDE M. COLLINS, M.D.,
Florida Association of General Surgeons .....*Jacksonville*
WENDELL J. NEWCOMB, M.D.,
Florida State Surgical Division, International College of Surgeons .....*Pensacola*
FRANCIS X. COOKE, M.D.,
Florida Society of Thoracic Surgeons .....*Miami*
HORACE D. ATKINSON, M.D.,
Florida Urological Society .....*W. Palm Beach*

COUNCIL ON VOLUNTARY HEALTH AGENCIES

HAWLEY H. SEILER, M.D., Chm. .....*Tampa*
HENRY R. COOPER, M.D.,
Florida Heart Association .....*Ft. Lauderdale*
LOUIS M. SALES, M.D., Florida Chapter, The Arthritis Foundation .....*Jacksonville*
CHARLOTTE C. MAGUIRE, M.D., Florida Society for Crippled Children & Adults .....*Orlando*
EARL E. WILKISON, M.D., Florida Division, American Cancer Society .....*Tallahassee*
FRANK L. CREEL, M.D., Florida Association for Mental Health .....*Pensacola*
HAWLEY H. SEILER, M.D., Florida Tuberculosis and Respiratory Disease Association .....*Tampa*
THOMAS S. EDWARDS, M.D., Florida Society for Prevention of Blindness .....*Jacksonville*
CHARLES H. CARTER, M.D., Florida Association for Retarded Children .....*Orlando*
JOHN H. WHITCOMB, M.D., United Cerebral Palsy of Florida .....*Pensacola*
THEODORE A. DIPPY, M.D.,
The National Foundation .....*Winter Park*
RUTH A. RICE SIMONS, M.D., National Multiple Sclerosis Society .....*Coral Gables*

FLORIDA MEDICAL FOUNDATION

EUGENE G. PEEK JR., M.D., President .....*Ocala*
WILLIAM J. DEAN, M.D., Vice President ....*St. Petersburg*
FLOYD K. HURT, M.D., Secretary-Treasurer ....*Jacksonville*

INVESTMENT PLAN COMMITTEE

BURNS A. DOBBINS JR., M.D., Chm. .....*Ft. Lauderdale*
CARL S. McLEMORE, M.D. .....*Orlando*
JOHN D. MILTON, M.D. .....*Coral Gables*
WILLIAM M. C. WILHOIT, M.D. .....*Pensacola*
JOHN M. BUTCHER, M.D. .....*Sarasota*
JOHN J. CHELEDEN, M.D. .....*Daytona Beach*
WILLIAM J. DEAN, M.D. .....*St. Petersburg*
JAMES J. DeVITO, M.D. .....*St. Augustine*
GEORGE S. PALMER, M.D. .....*Tallahassee*
JOSEPH C. VON THRON, M.D. .....*Cocoa Beach*
JAMES L. ANDERSON, M.D. .....*Miami*
LEON H. MIMS JR., M.D. .....*Coral Gables*

LEGAL COUNSEL

MARKS, GRAY, YATES, CONROY & GIBBS ..*Jacksonville*

CERTIFIED PUBLIC ACCOUNTANTS

LUCAS, HERNDON, HARMS & LUCAS .....*Jacksonville*

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: GP (AAGP) to join established GP in rapidly growing community. New 200 bed hospital. Write C-816, P.O. Box 2411, Jacksonville, Fla. 32203.

BUSY GENERAL PRACTITIONER needs associate. Florida license necessary. Salary first year, then partnership. Will consider pediatrician or Ob-Gyn willing to do GP. Desirable South Florida town with sports and recreation available on Lake Okeechobee, 90 miles from Miami. Edward B. McConville, M.D., 406 S. Deane Duff Ave., Clewiston 33440. Office phone 983-8531, Residence 983-8250.

PHYSICIAN WANTED: Resort area, central Florida, rewarding practice, no investment. Ob and surgery optional. Guarantee $20,000; should make $30,000 first year. Write C-830, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER wanted, preferably young, to establish his own practice in Miami Beach. A medical group guarantees to refer a minimum of $7,500 a year. Write C-820, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Physician to do general practice with two established G.P.s for association and eventual partnership. 35 bed approved JCAH hospital soon to expand—with modern Professional Arts Bldg. and Northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

Locum Tenens

LOCUM TENENS AVAILABLE: General practitioner, no Ob or major surgery. Write to P.O. Box 468, Miami, Fla. 33101.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

INTERNIST WANTED: To associate with established internist in greater Miami area. Terms open. Attractive fringe benefits. Large, active practice. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST: Board eligible or certified to associate with two physicians in the greater Miami area. Salary, leading to association in two years. Write C-831, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON: Board qualified to associate with an established surgeon. Initially on basis of office sharing and coverage. Two fully equipped locations. Write "Doctor," 1950 N.E. 47th St., Fort Lauderdale, Fla. 33308.

PEDIATRICIAN WANTED: Board certified or board qualified, to step into an active practice in desirable community on Gulf Coast. Write C-826, P.O. Box 2411, Jacksonville, Fla. 32203 or telephone (904) 763-8752.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd., W., Bradenton, Fla. 33505.

WANTED: Board eligible or certified internist with subspecialty interest to join established internists group in southeast Florida coastal community. Starting salary $21,000 with early full partnership. Write C-805, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

WANTED: OB-GYN, board certified or eligible, to join a small multi-specialty group in central Florida city of 70,000 with excellent hospital facilities. Terms open. Military obligation must be completed. Write C-836, P.O. Box 2411, Jacksonville, Fla. 32203.

ANESTHESIOLOGIST WANTED: Board certified or eligible to join group in private practice in South Florida. Florida license required. Write C-838, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST OR CARDIOLOGIST WANTED IMMEDIATELY to join well established group on Miami Beach. Excellent starting salary and full partnership offered. Contact Nathan N. Kimball, M.D., Professional Associates, 333 Arthur Godfrey Rd., Miami Beach, Fla. 33140. Phone 531-6755.

ASSOCIATE WANTED: For obstetrical and gynecological practice in Palm Beach, Florida in an active existing two man partnership. Board qualified or certified and has completed his military obligation. Florida license necessary. Contract Mr. Harold Kwart, Medical Business Consultants, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

INTERNIST: A mature doctor to join Pan Am's Industrial Health staff at Cape Kennedy and help provide an overall industrial health program to contractor personnel. U.S. citizenship is required. The staff is composed of a director, 8 Md's, 24 RN's and 8 technicians. Company benefits include reduced rate air travel, paid vacations, paid family hospitalization insurance and life insurance at nominal cost. Send resume in confidence to Mr. R. E. Arendas, Dept. 410G, Aerospace Services Division, Pan American World Airways, Inc., 750 S. Orlando Ave., Cocoa Beach, Fla. 32931. An equal opportunity employer, M&F.

INTERNIST board eligible or certified for expanding clinic in Palm Beach County. Gastroenterology film and fluoroscopy training desirable. Excellent hospitals. Academic, financial and personal satisfaction. Write C-822, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

WANTED: General practitioner or internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Guarantee $20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

WANTED: General practitioner or internist for an association and partnership. Busy practice in Surfside, Miami Beach, Florida. First year income $16,000 to $18,000. Three years to full partnership. Write S. Nelson Tippett, M.D., 9452 Harding Ave., Surfside, Miami Beach, Fla. 33154.

EMERGENCY ROOM PHYSICIANS: Modern hospital emergency unit. Florida license necessary; fee for service plan. 700 beds, 25,000 patients annually. St. Petersburg, Florida offers many activities in cultural, sports and educational realms. Mound Park Hospital is a teaching hospital with an active approved internship and residency program. For additional information write Robert A. Biles, M.D., Chief of Staff, Mound Park Hospital, 701 Sixth Street, S. St. Petersburg, Fla. 33701.

WANTED: GP or General Surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

EMERGENCY ROOM PHYSICIAN: One vacancy at Broward General and one at North District hospitals. Florida license required. Minimum professional fee $20,000 per annum with annual review to $25,000 at end of second year. Regular 8 hour shift. Excellent employee benefit program. Contact District Director, North Broward Hospital District, 1600 S. Andrews Ave., Fort Lauderdale 33316.

G. P. OR INTERNIST WANTED: Unique opportunity. Beautiful exclusive area central Florida. Will introduce acceptable individual to patients. Open immediately, investment optional. Write C-841, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: E.N.T., internist (board qualified) or G.P. to associate with new group in new offices in central Florida community of 40,000. Terms negotiable. Write C-840, P.O. Box 241, Jacksonville, Fla. 32203.

MEDICAL DIRECTOR WANTED: For large industrial plant. Background of industrial medicine, internal medicine or general practitioner acceptable. Medical department includes modern first aid facilities and 24 hour RN coverage. Excellent benefits. Salary open. An equal opportunity employer. Contact Personnel Manager, St. Regis Paper Company, P.O. Box 1591, Pensacola, Fla. 32502.

WANTED: G.P. or internist to associate with busy G.P. in Miami, Florida. Future partnership in mind. Excellent salary plus percentage. Florida license required. Benton B. Perry, M.D., 1240 N.W. 119th St., Miami, Florida 33167. Phone MU 8-4321.

---

situations wanted

ORTHOPEDIC SURGEON: Age 40, board certified, F.A.C.S., Florida license, eight years busy private Midwest practice, wishes to practice in Florida. Partnership in college town preferred. Write C-825, P.O. Box 2411, Jacksonville, Fla. 32203.

OBSTETRICIAN-GYNECOLOGIST, board eligible, Junior Fellow ACOG, Florida license, interested in partnership or association. Thomas V. McKee, M.D., 110 Vilsack Road, Glenshaw, Pa. 15116.

PATHOLOGIST, CP and PA certified, 14 years department director 300 bed hospital. Director school medical technology. Radioisotopes licenses. Teaching challenge welcomed. Desire relocation South Florida (licensed). Available immediately. Write C-835, P. O. Box 2411, Jacksonville, Fla. 32203.

PERIPHERAL VASCULAR SURGEON, board certified, Florida licensed, desires partnership or group practice. Available July 1. Write C-833, P.O. Box 2411, Jacksonville, Fla. 32203.

UROLOGIST, 42, board certified, wants to relocate in Florida. Has Florida license. Prefers association with urology group or clinic. Please contact Medical Placement, 1371 Peachtree St., N.E., Atlanta, Ga. 30309.

practices for sale

FOR SALE OR LEASE: Active practice 21 years. Spacious 12 room modernly equipped establishment, new 62 bed hospital in Sebring, Fla. Contact Stanley K. Wallace, M.D., 32 N. Commerce St., Sebring, Fla. 33870. Telephone 385-8640.

ESTABLISHED GENERAL PRACTICE of deceased physician available. Share personnel and equipment with other MD's in same building. Practice also suitable for internist. Contact University Clinic, 2506 Ponce de Leon Blvd., Coral Gables 33134. Telephone (305) 446-6474.

FOR SALE: Successful ear, nose and throat practice in greater Miami area. Write C-837, P. O. Box 2411, Jacksonville, Fla. 32203.

real estate

FOR SALE OR LEASE: Florida luxurious medical center in affluent Galt Ocean Mile, Ft. Lauderdale. Specialty building with central reception, ir dividual practice, high gross income. Fall occupancy. Write C-839, P.O. Box 2411, Jacksonville, Fla. 32203 or phone: 565-1888.

FOR RENT: Medical office complete. New. RENT FREE to December 1968. Write Suite 111, 4800 N.E. 20th Terrace, Fort Lauderdale, Fla. 33301.

MEDICAL SUITES: To your order. Across from Memorial Hospital in Hollywood. Call 989-6000 or write Hollywood Hills Professional Center, 921 N. 35th Ave., Hollywood, Fla. 33021.

MEDICAL OFFICE FOR RENT: Excellent opportunity. Physician leaving area. 3 treatment rooms, darkroom, lab, carpeted private office, etc. Rental only $210 monthly. St. Petersburg, Florida 33703. Phone 526-3868.

miscellaneous

FOR SALE: Brand new Birtcher Hyfracator with special Epilation needle. Model 712. First offer nearest $90.00 buys it. Write 1246-79th St., S., St. Petersburg, Fla. 33707.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7—6062

Index to Proceedings

A. H. Robins Award ... 622

Aesculapius Award ... 619

Baldwin Lecture ... 619

Board of Governors Report ... 643

Certificate of Appreciation ... 648

Certificate of Recognition ... 623

Council Reports

- Allied Professions and Vocations ... 634
- Judicial ... 650
- Legislation and Public Agencies ... 660
- Medical Economics ... 665
- Medical Services ... 635
- Scientific Activities ... 628
- Special Activities ... 654
- Specialty Medicine ... 629
- Voluntary Health Agencies ... 619

General Session ... 619

House of Delegates

- First House ... 620
- Second House ... 626

Physician-Legislator Resolution ... 623

President's Address ... 615

Reference Committee I ... 628

" " II ... 634

" " III ... 643

" " IV ... 657

" " V ... 665

Remarks of the Speaker ... 621

Resolutions

- Antibody Rubella Screening Tests (68-21) ... 632
- Blue Shield of Florida (68-6) ... 670
- Certificates of Good Health and Premarital Examinations (68-11) ... 639
- Chemical Face Peeling (68-18) ... 632
- Cohen, Wilbur J. (68-23) ... 671
- Editor of the Journal (68-24) ... 671
- Finger Surgery Technique (68-5) ... 632
- Highway Safety Laws (68-19) ... 663
- History of Medicine Museum (68-8) ... 655
- Individual Responsibility Program (68-15) ... 671
- Medical Meetings (68-14) ... 656
- Medical Quackery (68-13) ... 663
- Membership Classifications (68-12) ... 656
- Otolaryngology (68-4) ... 655
- Preventive Medical Immunization (68-3) ... 639
- Relative Value Studies Escalator Clause (68-2) ... 670
- Service Policies of Blue Shield (68-1) ... 670
- Therapeutic Abortion (68-20) ... 658
- Utilization Review Liability Exemption (68-7, 68-9) ... 659
- Violence and Lawlessness (68-22) ... 640
- Workman's Compensation (68-17) ... 669

Florida Medical advertisers

Abbott Laboratories
Enduron 598a
Enduronyl 598a
Eutron 598a, 599

Anderson Surgical Supply Co. 678

Breon Laboratories
Fergon 682

Bristol Laboratories
Tetrex F 598

Burroughs-Wellcome Co.
Neosporin 694a

Campbell Soups 648a

Convention Press 678

Dorsey Laboratories
Triaminic 686a

Dow Chemical Company
A & I Bioproducts 594

Geigy Pharmaceuticals
Hygroton 694a
Tegretol 694a
Tofranil 676-677

Glenbrook Laboratories
Bayer Aspirin 648a

Guild of Prescription Opticians 611

Highland Hospital, Inc. 692

Hill Crest Hospital 682

Hynson, Westcott & Dunning, Inc.
BSP 591

Lakeland Manor 691

Lederle Laboratories
Achrostatin 680, 684
Bamadex 612-613
Declostatin 593
Peritinic 701
Tine Test 686, 698

Eli Lilly & Co.
Darvon 606
Trinsicon 648a

Medical Supply Co. 681

Merck, Sharp & Dohme
Hydropres 602-604

Parke-Davis & Co.
Povan 600-601

P. L. Dodge Memorial Hospital 678

PM of Florida 691

William P. Poythress & Co.
Trocinate 681

Riker Laboratories
Norflex 590

A. H. Robins, Inc.
Ambar 688

Roche Laboratories
Valium 605
Librium ..... Back Cover

G. D. Searle Co.
Flagyl 648a

Strasenburgh Laboratories
Omni-Tuss 648a

Stuart Co.
Mylanta 648a

Surgical Supply Co. 678

Tucker Hospital, Inc. 690

S. J. Tutag
Cydril 693

Wyeth Laboratories
Pen Vee K 614

Whenever anxiety induces or intensifies clinical symptoms

Library
New York Academy of Medicine
2 East 103rd St
New York N Y J 12-68
10029

Librium®

(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination, on proper dosage~Has wide margin of safety

LIBRARY
JUL 15 1968
NEW YORK ACADEMY OF MEDICINE

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Also available: **Libritabs**™ *(chlordiazepoxide) 5-mg, 10-mg, 25-mg tablets*

BALCONY

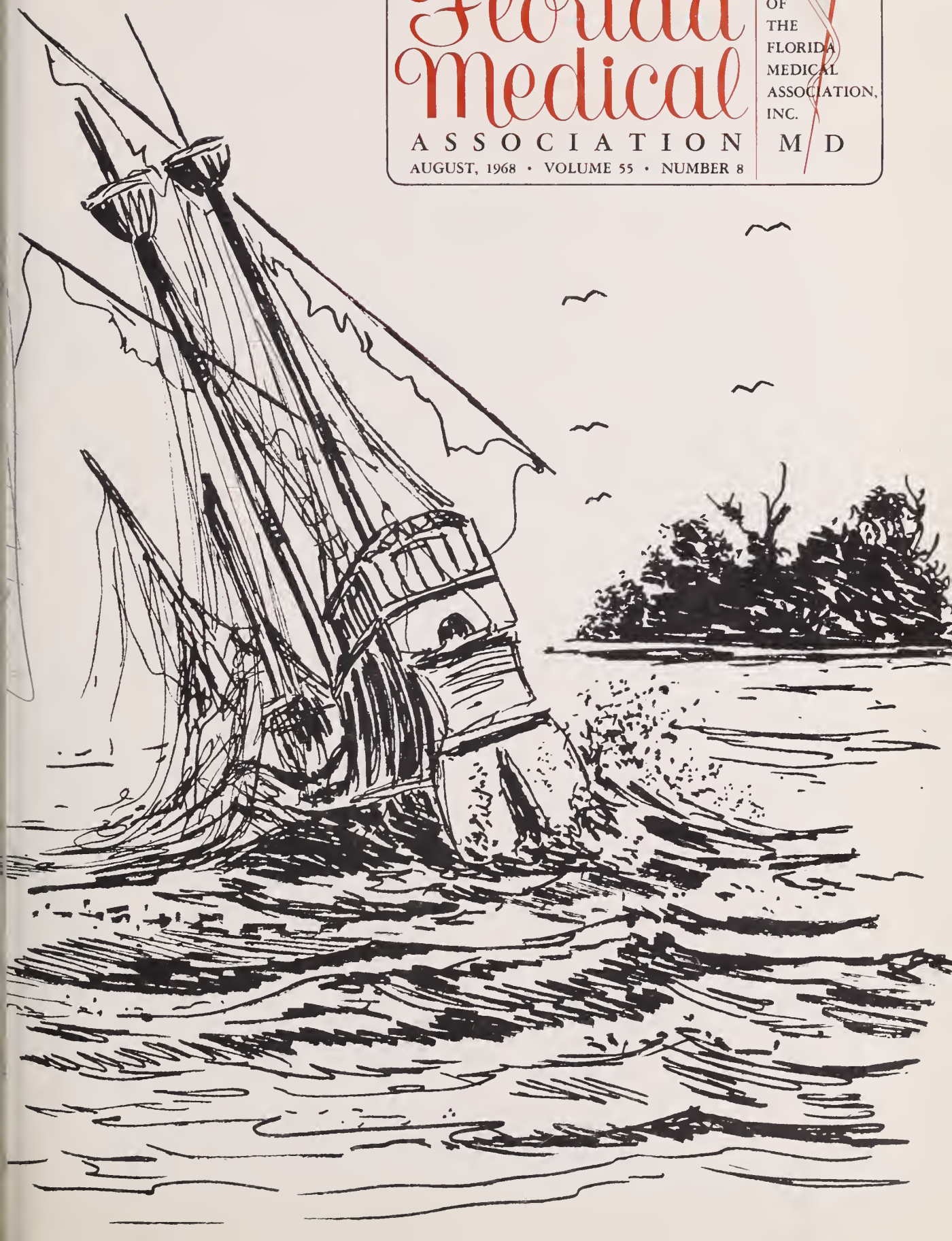
THE JOURNAL OF THE

Florida Medical ASSOCIATION

AUGUST, 1968 • VOLUME 55 • NUMBER 8

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M/D



The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

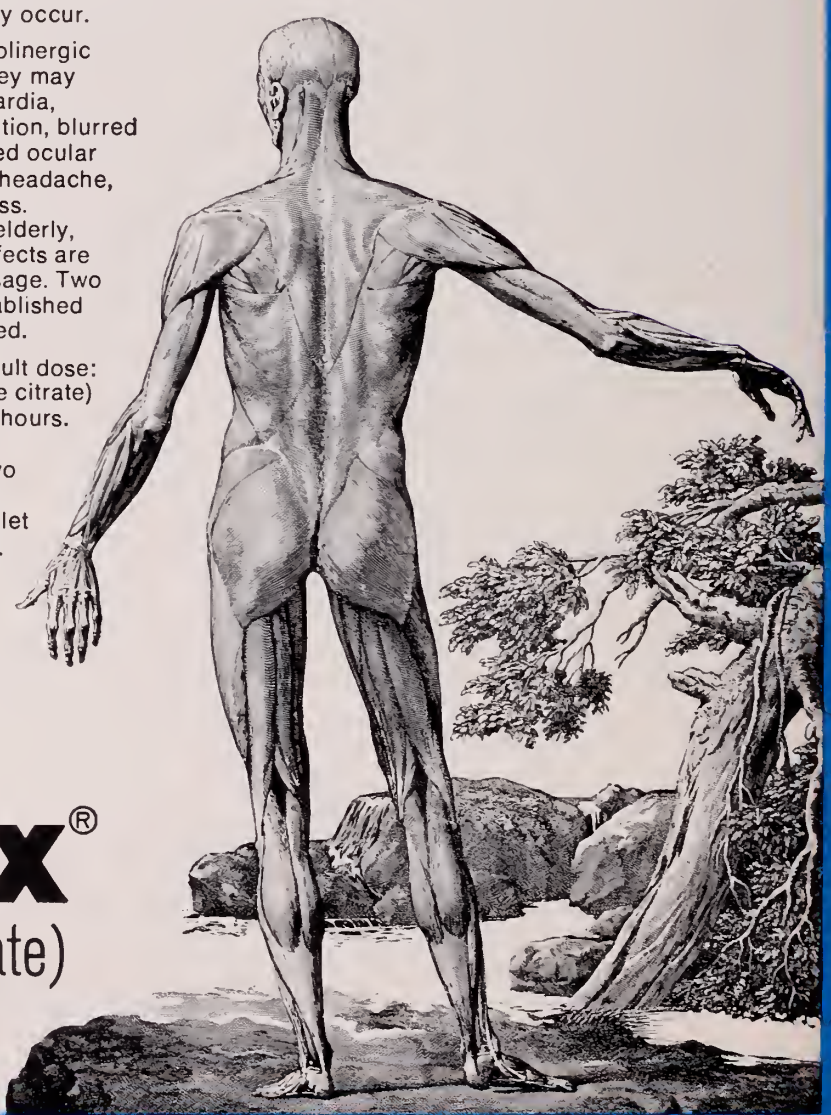
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)



LACTINEX®

TABLETS & GRANULES

■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX

THE JOURNAL OF THE
Florida Medical
ASSOCIATION
AUGUST, 1968 • VOLUME 55 • NUMBER 8

scientific

Septic Arthritis Due to Hemophilus Influenzae 723
AAROLYN M. VISINTINE, M.D., CATHERINE A. POOLE, M.D. AND WILLIAM L. NYHAN, M.D., Ph.D.

history

Medicine in St. Augustine During the Spanish Period 731
WILLIAM M. STRAIGHT, M.D.

Dr. Howell Tyson Lykes, Founder of an Empire 742
JAMES M. INGRAM, M.D.

Old Doc Anna 749
AS TOLD BY DR. ANNA DARROW

A Short History of the University of Florida College of Medicine to 1960 757
MARK V. BARROW, M.D.

Life in the Spanish Colonial Hospitals in the Late 18th Century 765
WILLIAM M. STRAIGHT, M.D.

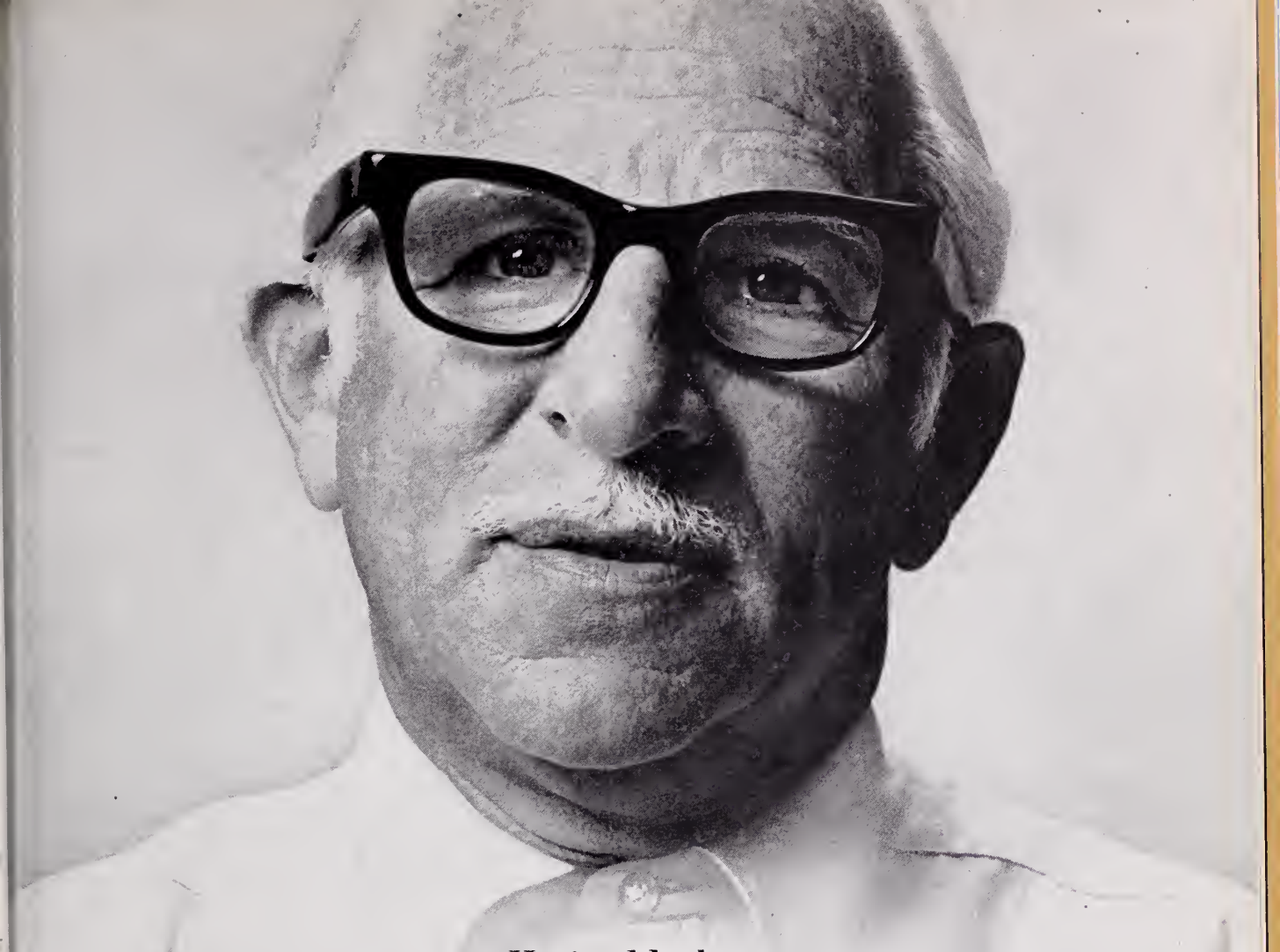
sections

Comment 777
Editorial 773
Organization 783
President's Page 713

information

Advertisers 795
Classified 789
Florida Organizations of Medical Interest 794
Information for Authors 711

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

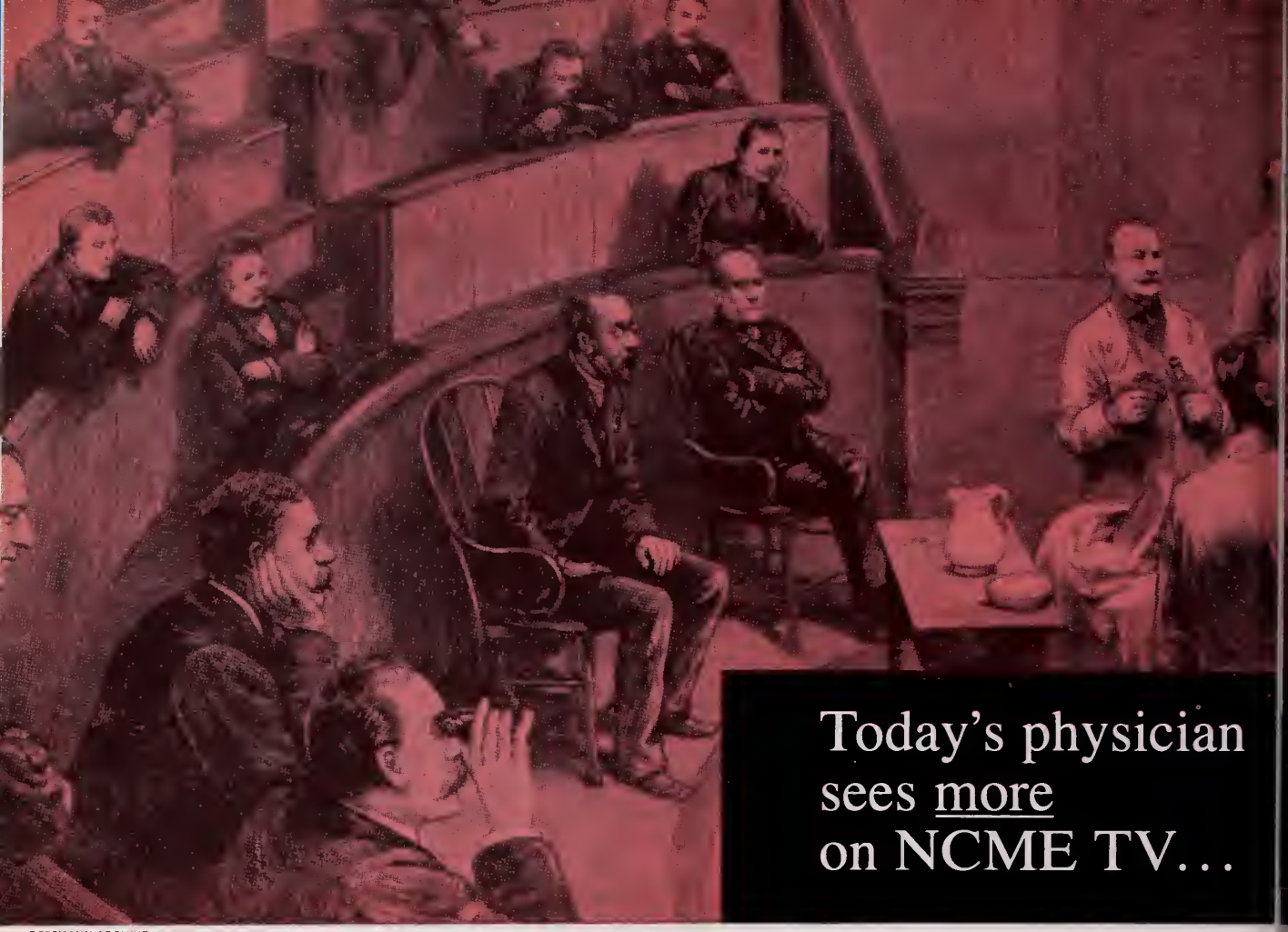
Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York



Today's physician sees more on NCME TV...

BETTMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number, 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P.O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE

Florida Medical

ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

OSCAR W. FREEMAN, M.D.
Assistant Editor

RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

GEORGE H. ROWE JR.
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor



AUGUST COVER

The sea brought tragedy and adventure
El Principe was driven ashore in 1579
Thus landed Juan de LeConte
Physician to the colony now St. Augustine

Thanks to artist Newton Randum

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin 5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



AMA Annual Meeting

I doubt if there are more than 200 of our some 6,000 members of the Florida Medical Association who realize how hard working our AMA Delegates are, and specifically how our own delegates from Florida diligently and earnestly stay on the job and try their best to represent our Association and to carry out the mandates of our own House of Delegates. They do this even though occasionally they may not agree with the intent of the resolution they may be sponsoring. After observing two annual meetings and one interim meeting of the AMA House of Delegates closeup, I am still more impressed with the sincerity and knowledge of the delegates who conduct our business. Every one of our members should, at some time, go to all the meetings of the delegates and reference committees. You may not always agree with the final decision of the majority but you will certainly have to acknowledge that they are doing the best they can and should be given "A" for effort.

I was impressed with the way that the Speaker of the House at the San Francisco meeting (after consultation with the general officers and Board of Trustees, I am sure) was prepared to handle the expected interruption of the first meeting by a minority group said to be representing the "Bay Area Poor People's Campaign," a program of the Southern Christian Leadership Conference. As was expected, two of the members of this organization appeared at a microphone, interrupting the orderly proceedings of the House. They previously had been advised that they could be heard, but in a way that all are heard with a grievance—that is by appearing first before the appropriate reference committee and later before the House if indicated. This advice was not accepted, the group preferring to appear dramatically with their speeches before the House in full glare of the television cameras. Meanwhile, their cohorts were picketing the front of the hotel.

Somehow the microphone at which they were speaking became mechanically defective and no one could hear what they were saying. They kept on talking to a dead microphone for 30 or 40 minutes then gave up and left the building. I am sure they were hoping that they would be forcibly removed from the hall before national TV and other news media. Somehow, the microphones were working again as soon as they left.

One thing happened in San Francisco that should make us all proud. Harold Parham, our executive director, was elected president-elect of the American Association of Medical Society Executives (See page 785). Now the whole country knows what all of us knew—we've got the top man as our executive director. Congratulations, Harold.

Jack A. Cleveland



tones down the "explosive gut"

helps restore normal motility and tone

CANTIL®
(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

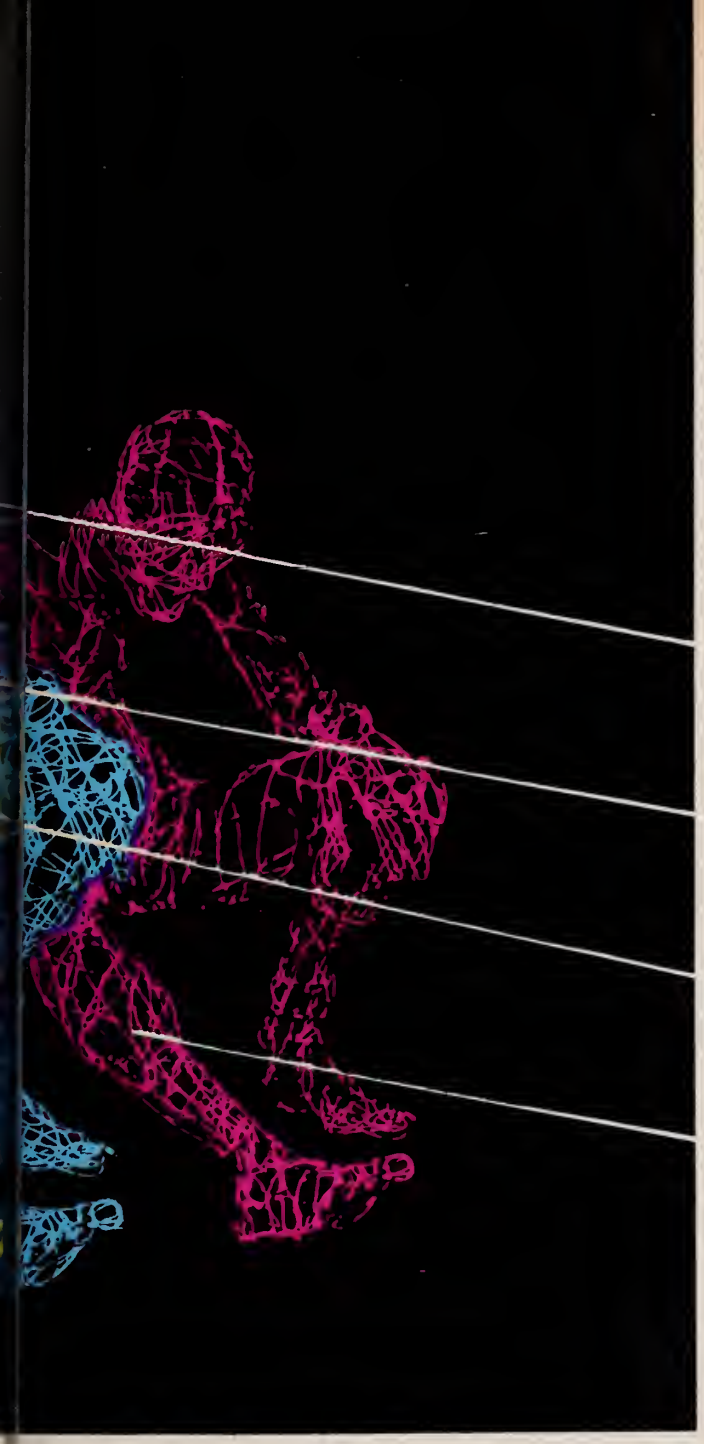
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropria investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequa vitamin B_{12} therapy may result in hematologic remission but ne rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematin concentrate with intrinsic factor, Lilly]) usually prevent, halt, improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potenti tion of absorption of physiological doses of vitamin B_{12}. If resis ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single re men fits all cases, and the status of the patient observed follow-up is the final criterion for adequacy of therapy. Perioc



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly



choose an experienced candidate—
millions of doses prescribed

Benadryl®

(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

You won't have to wait for these results to come back from the lab. Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests. The system can be used to measure hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. Write today for full details.

*Trademark of The Dow Chemical Company

DOW

early relief from

DEPR



At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves . . . mood fluctuations lessen . . . sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type . . . any degree of severity.

LAKESIDE

IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, ness, palpitation, delayed urination, agitation stimulation ("jumpiness," "nervousness," "anxi "insomnia"), bad taste, sensory illusion, tin sweating, drowsiness, headache, hypoten (orthostatic), flushing, nausea, cramps, weakn blurred vision and mydriasis, rash, tremor, all (general), altered liver function, ataxia and e pyramidal signs, agranulocytosis.

Additional side effects more recently repo include: seizures, eosinophilia, confusional s with hallucinations, purpura, photosensitivity, g torrhea, gynecomastia, and impotence. Side ef which could occur (analogy to related drugs clude weight gain, heartburn, anorexia, and and arm paresthesias.

DOSAGE: Optimal results are obtained at a do of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hy chloride) tablets of 25 mg.; bottles of 50, 500 1,000; and tablets of 50 mg. in bottles of 30, and 1,000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53

ESSION

NORPRAMIN®
(desipramine hydrochloride)

improvement often begins in 2 to 5 days



See package insert for complete prescribing information.



Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

a latent peptic ulcer. The patient should be structed to take doses immediately after s or with milk to minimize gastric upset. rash occasionally occurs. If it does, ptly discontinue the drug. Agranulocy- exfoliative dermatitis, Stevens-Johnson rome, Lyell's syndrome (toxic necrotiz- pidermolysis) or a generalized allergic ion similar to a serum sickness syn- e may occur and require permanent rawal of medication. Agranulocytosis ccur suddenly in spite of regular, re- d normal white counts. Stomatitis, sali- gland enlargement, vomiting, vertigo and ior may occur. Leukemia and leukemoid ions have been reported. While not defi- attributable to the drug, a causal rela- hip cannot be excluded. Thrombocyto- penic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

Geigy (B) 46-800-A

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-5806AR

From the First Family of Tetracycline– One of the 31 useful dosage forms in the ACHRO Family

ACHROSTATIN® V Capsules

Tetracycline HCl 250 mg /Nystatin 250,000 units



The lowest priced tetracycline-nystatin combination

Lederle

329-8/6094



Vacation trip....

Motion sickness?



This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

ROHRER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

This Emetrol advertisement will appear in the following medical journals

American Jl. of Diseases of Children
Jl. of Pediatrics
New York State Jl. of Med.
California Medicine
Illinois Med. Jl.
State Journal Group—33 Journals

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazone) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydrocortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Also available: Furacin® Otic (nitrofurazone with nifuroxime and diperodon HCl). The wide antibacterial range of Furacin is augmented by the antimycotic activity of Micofur® (nifuroxime). Diperodon hydrochloride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacterial otitis externa, otomycosis or bacterial otitis media (when the eardrum is perforated).

Precautions: Sensitization to nitrofurazone may occur with prolonged use and is more likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Contraindications: The usual contraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesions of skin or ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrofurazone, and 1.0% hydrocortisone acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrofurazone, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrochloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

™Originators and Developers of The Nitrofurans
EATON LABORATORIES
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone/hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl



Part of the fine art of medicine



DARVON® COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206

Lilly

800118

Florida Medical | scientific

Septic Arthritis Due to Hemophilus Influenzae

Aarolyn M. Visintine, M.D., Catherine A. Poole, M.D.
and William L. Nyhan, M.D., Ph.D.

Infection due to Hemophilus influenzae occurs in infancy and early childhood; the principal type of disease caused by this organism is meningitis. Septic arthritis is a less common manifestation of disease due to Hemophilus influenzae.

Most reports of septic arthritis due to H. influenzae were of single patients and from 1899 to 1966 numbered less than 50.[1-4] More recently, Nelson and Koontz[5] have reported 16 patients observed with septic arthritis from 1955 through 1965 in a series of 117 patients with suppurative arthritis.

In view of the observation of an apparent increase in the past two years in the number of patients with H. influenzae arthritis admitted to the Jackson Memorial Hospital, we wondered whether or not this was paralleled by an increase in all types of H. influenzae infection and, therefore, we undertook a review of our experience with this and other types of serious infection due to this organism. The overall incidence of Hemophilus infections has not changed significantly during the past eight years, but the relative proportion of different systems affected has changed. A series of 13 patients with septic arthritis due to H. influenzae has been observed during this period.

Material and Methods

Review of the hospital records of the Jackson Memorial Hospital from 1959 through 1966 yielded a series of 178 patients in whom H. influenzae was identified as the causative agent. An additional ten patients were excluded because the available material was inadequate or could not be satisfactorily evaluated.

Results

General Observations. The number of patients hospitalized each year with serious clinical disease from H. influenzae has remained virtually constant at 20 to 24 patients per year over the past eight years. During this period of time the total hospital census has remained about the same (average 35,000 patients admitted per year); however, the pediatric inpatient census has increased from 1,800 patients in 1959 to 3,000 patients in 1966.

The types of disease seen are indicated in Table 1. Some patients had more than one man-

Table 1. — Serious Infections due to H. Influenzae, 1959-1966

	No. of Patients
Septicemia	140
Meningitis	133
Pneumonia	25
Arthritis	13
Cellulitis	8
Mastoiditis	2
Epiglottitis	1
Pericarditis	1
Subacute bacterial endocarditis	1
Retropharyngeal abscess	1
Total	178

From the Departments of Pediatrics and Radiology, University of Miami School of Medicine and Jackson Memorial Hospital, Miami.

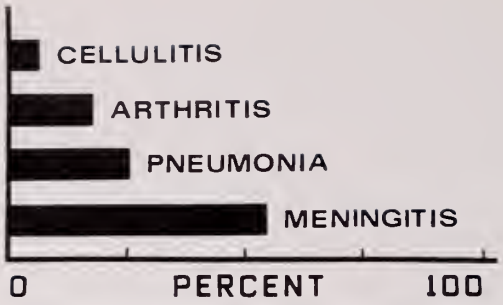


Fig. 1. — Proportion of patients with major manifestations of septicemia seen 1965 to 1966. The total number of patients was 46.

ifestation of infection. Of the total 178 patients, 140 had septicemia (alone or with specific localization). Thirty-seven of the remaining 38 patients had meningitis. One patient had septic arthritis with a negative blood culture.

H. influenzae was isolated by blood culture from 125 children and 15 adults during the eight-year period. During this period of time the number of patients admitted each year from whose blood H. influenzae was isolated has remained about the same. An average of 17.5 cases of Hemophilus influenzae septicemia per year has been documented. At the same time, the total number of blood cultures processed in the hospital laboratory has more than doubled. There were 4,900 blood cultures processed in 1959 and 10,800 in 1966. The same pattern applies for H. influenzae meningitis: more examinations of the cerebrospinal fluid are being made in seriously ill infants and children; there has been no increase, but actually a slight decrease in the number of spinal fluid cultures positive for H. influenzae in 1965 and 1966.

The most common manifestation of infection with this organism was meningitis. Of the 140 patients with positive blood cultures, 96 had meningitis, all of whom were children; 25% of these had subdural effusions. Two children with meningitis and septicemia also had acute mastoiditis.

Pneumonia was present in 25 patients with sepsis. There were 16 children and nine adults in this group. Four of the adults were known to be alcoholic, three others had another concomitant serious disease (acute myocardial infarction, metastatic carcinoma, ruptured aortic aneurysm). One third of all patients with pneumonia had pleural effusion.

Acute epiglottitis was the clinical diagnosis in only one child with septicemia.

A 19-year-old Caucasian man with a patent ductus arteriosus had subacute bacterial endocarditis; H. influenzae was isolated from nine consecutive blood cultures. A 13-day-old infant who developed acute congestive heart failure and expired seven hours later was found to have had fibrinous pericarditis, and H. influenzae was found in cultures of the blood, cerebrospinal fluid and pericardial fluid.

Twelve of the 13 patients with septic arthritis and all eight with cellulitis had septicemia. The relative proportion of patients with the more common clinical manifestations of Hemophilus infection for the years 1965 and 1966 are indicated in Figure 1. Figure 1 also compares the recent increase in influenzal arthritis with the gradual but perceptible decrease in incidence of purulent meningitis.

H. influenzae was isolated from the blood of 125 children and 15 adults. The age groups are given in Table 2. Approximately two thirds were

Table 2. — Age Distribution of Patients With Positive Blood Cultures

Less than 6 months	25
6 months to 2 years	67
2 to 7 years	33
19 to 61 years	15
Total	140

less than two years of age. There were no patients between 7 and 19 years of age. There were 23 Caucasian males and 16 females, while among Negroes there were 48 males and 53 females. A mortality rate of about two patients per year did not change significantly in the period of study.

Septic Arthritis.—The clinical and pathological features of the patients with septic arthritis are indicated in Table 3.

The youngest patient was six weeks of age and the oldest was six years; males and females were affected with equal frequency. The most commonly involved joints were the knee (five patients) and the elbow (four patients). There were two patients with wrist and two with ankle joint involvement and one patient with septic arthritis of the hip. Arthrocentesis was performed in ten patients and the blood was cultured in all of the patients. H. influenzae was isolated in culture of the joint fluid in seven patients and by blood culture in 12 of the 13 patients. Among other complications of septicemia, one child had pneumonia and two had meningitis. Five patients developed roentgenographic evidence of osteomye-

TABLE 3.—CLINICAL AND PATHOLOGICAL FEATURES OF PATIENTS WITH SEPTIC ARTHRITIS

Patient No.	Sex	Age	Involved Joints	Arthrocentesis	Cultures			Duration of Antibiotic Therapy	Associated Diagnoses and Morbidity
					Joint Fluid	Blood	Cerebrospinal Fluid		
1	F	17 mo	left knee	yes	H. influenzae	H. influenzae		14 days	Bilateral otitis media
2	M	16 mo	right ankle	yes	gram-neg. rods on smear	H. influenzae		21 days	
3	M	6 mo	right wrist	no		H. influenzae		14 days	
4	F	10 mo	left elbow	yes	no growth	H. influenzae	H. influenzae	55 days	Meningitis with bilateral subdural effusion. Osteomyelitis, left humerus
5	F	9 mo	left hip	no		H. influenzae		35 days	Left otitis media
6	M	6 yr	right ankle	yes	H. influenzae	H. influenzae	No growth	22 days	Osteomyelitis, right fibula
7	F	19 mo	left knee	no		H. influenzae		26 days	
8	M	6 wk	right elbow; left knee	yes yes	gram-neg. rods on smear	Positive-organism in question	H. influenzae	44 days	Meningitis with bilateral subdural effusion and subsequent hydrocephalus. Osteomyelitis, right humerus and right ulna.
9	M	14 mo	right elbow	yes	H. influenae	H. influenzae		31 days	Osteomyelitis, right humerus
10	F	9 mo	right elbow	yes	H. influenzae	H. influenzae	No growth	56 days	Osteomyelitis right humerus and right ulna
11	M	6 mo	left wrist	yes	H. influenzae	H. influenzae		28 days	Bilateral otitis media
12	F	28 mo	left knee	yes	H. influenzae	No growth		28 days	
13	M	3½ mo	right knee	yes	H. influenzae	H. influenzae		27 days	Pneumonia, right upper and right lower lobe with pleural effusion



Fig. 2. — Case 1. Frontal and lateral views of the right knee at the time of admission demonstrate soft tissue swelling and marked distension of the joint capsule, compatible with septic arthritis. Osteomyelitis is not evident radiographically.

litis of bones adjacent to the involved joint. None of the 13 children expired. The histories of two representative patients follow.

Report of Cases

Case 1.—A 4-month-old Negro boy was admitted with swelling of the right knee of one week's duration.

He was the product of a normal pregnancy and delivery. Birth weight was 7 lbs., 8 oz. Examination revealed a well-developed, well-nourished, acutely ill, icteric Negro boy. The temperature was 98°F, the pulse was 180/min. and the respirations 60/min. There was dullness to percussion, diminished breath sounds and rales over the right upper lung field. The liver edge was palpated 4 cm. and the spleen 2.5 cm. below the costal margin. The knee was warm, red, tender, diffusely swollen and fluctuant. Active and passive motion of the knee joint were limited by pain and swelling.

Roentgenograms of the chest showed consolidation of the entire right upper lobe and a minimal infiltration of the right lower lobe. Roentgenograms of the right knee showed soft tissue swelling and marked distension of the joint capsule. The regional bones were demineralized in appearance, but bone destruction was not evident (Fig. 2).

The right knee joint was aspirated and 10 ml. of creamy yellow pus was obtained. Gram-stain of this material showed gram-negative pleomorphic rods and culture was positive for H. influenzae. Smear of the joint fluid showed 98% polymorphonuclear neutrophils. The protein was 4.8 g. and the fluid glucose level was less than 5 mg./100 ml. Lumbar puncture yielded clear fluid with no cells, normal glucose and protein content and a negative culture. The hemoglobin was 8.8 g./100 ml. and the hematocrit 22. The white blood cell count was 11,600 with 72% neutrophils. The bilirubin was 8.61 direct, and 15.06 total mg./100 ml. The Coombs test result was negative. Hemoglobin electrophoresis showed hemoglobin A and S. VDRL was non-reactive. Glucose-6-phosphate dehydrogenase was normal. Two blood cultures obtained on admission were positive for H. influenzae.

The infant was treated with chloramphenicol, kanamycin and sulfisoxazole. He improved slowly. The serum bilirubin was normal on the fifth hospital day. Roentgenograms of the chest showed clearing of the right upper lobe infiltrate on the 23rd hospital day. The inflammation of the knee subsided by the 19th hospital day and all therapy was discontinued by the 27th day. Roentgenograms of the knee showed no evidence of bone destruction.

Case 2.—A 9-month-old Negro girl was admitted with a four-day history of irritability, fever and reluctance to move her right arm. The right elbow became swollen and was tender to the touch.

Physical examination revealed a well-developed, well-nourished irritable Negro girl. Temperature was 104°F. The right elbow was warm, swollen and tender. Passive motion at the joint evoked pain.

Roentgenogram of the chest showed no infiltrate. Roentgenograms of the right arm showed soft tissue swelling about the elbow, but there was no evidence of bone destruction. Arthrocentesis of the right elbow joint was performed and smear of the material obtained revealed gram-negative pleomorphic rods. The blood culture and culture of the aspirate from the right elbow joint were both positive for H. influenzae, type b. Lumbar puncture revealed 4 leukocytes (all mononuclear cells) and 34 red blood cells. Culture was negative. The protein was 16 mg./100 ml. and the glucose level was 80 mg./100 ml. The hemoglobin was 8.8 g./100 ml. and the hematocrit was 33. The white blood cell count was 8,750 with 64% neutrophils.

Treatment was given with penicillin and chloramphenicol. Follow-up roentgenograms of the right arm on the fifth hospital day showed periosteal elevation along the distal humerus and proximal ulna. Figure 3 shows oblique and frontal views of the right elbow on the 14th hospital day. Chloramphenicol was continued for a total of 56 hospital days. The child's hospital course was one of slow progressive improvement. She was discharged on the 63rd hospital day. The blood of this infant and her mother were tested by Dr. James Connor for bacteriocidal activity against H. influenzae as described by Fothergill and Wright.[7] The level was reduced in the mother and virtually absent in the infant.

Discussion

An increased incidence of septic arthritis in general was reported by Nelson and Koontz,[5] who related this to an increase in hospital admissions. They also observed an increase in the proportion of patients with arthritis due to H. influenzae, as 87% of their patients with arthritis due to this organism were observed during the years 1961 through 1965. They considered that this might result from a possible increase in the frequency of Hemophilus infections as a whole or from improved methods for the isolation of the organism. None of these explanations appear to be consistent with our data.

In our series, 60% of the patients with H. influenzae arthritis have been seen in the last two years of study. During this same period of time there has been no real change in the incidence of Hemophilus infections as a whole. The quality of bacteriological procedures has improved in recent years. In addition, general employment of these tools has become more liberal. The increase in the number of patients with influenzal arthritis, however, is not simply a reflection of a greater number of patients admitted to the hospital or of greater readiness to perform blood cultures, since the incidence of positive cultures has not increased. Also, it seems unlikely that any of the antibiotics introduced in the past eight years could have affected the incidence or clinical manifestations of H. influenzae disease.

Because of a heightened awareness of the frequency and importance of septic arthritis, arthrocentesis has been performed more often in recent years and could account for an increased incidence. Positive blood cultures, however, were present in all patients except one. Patients with septic arthritis due to H. influenzae, if not promptly diagnosed, might be expected to develop meningitis with some frequency (Fig. 4). If then diagnosed and treated for the meningitis, the septic arthritis might subside without ever being apparent. In this sense, the changing incidence could reflect improved diagnostic activity and the prevention of meningeal infection. It does seem unlikely that any of the patients in this series would not have been recognized as having joint involvement. They all had clinical and radiographic evidence of acute arthritis. Nevertheless, it has been our experience that septic arthritis in infants is often overlooked and this is particularly true in a desperately ill infant with meningitis.

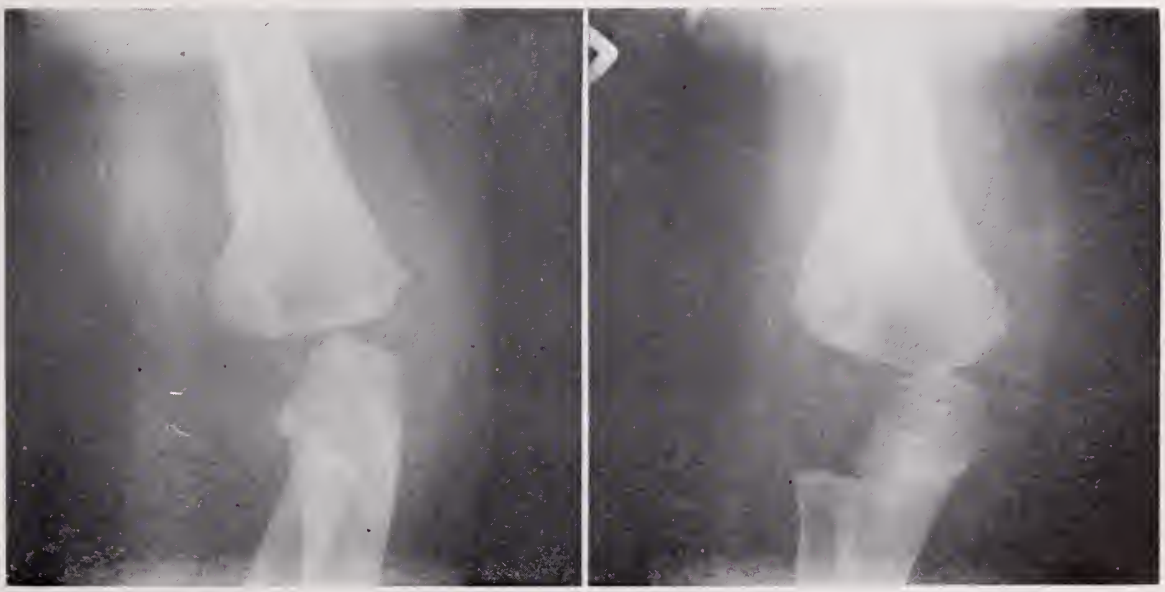


Fig. 3. — Case 2. Oblique and frontal views of the right elbow on the 14th hospital day reveal periosteal elevation and new bone formation on the distal humerus. Minimal periosteal change is also evident along the posterior aspect of the ulna (left) and residual soft tissue swelling is evident medially (right).

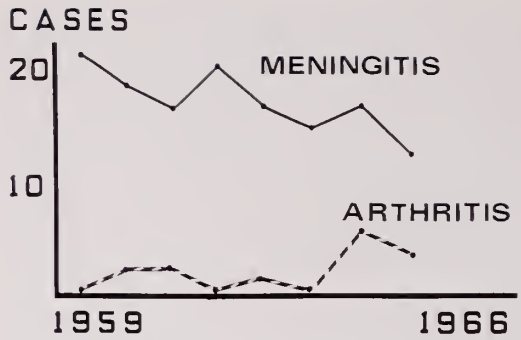


Fig. 4. — Relative incidence of meningitis and septic arthritis due to H. influenzae. The data are the number of patients per year.

Septic arthritis may evolve in three distinct ways: 1) direct inoculation of bacteria into the joint incidental to trauma, such as kneeling on a needle; 2) extension from an adjacent soft tissue or bony focus of infection (this is a particularly common mechanism in osteomyelitis of the neck of the femur in infants), and 3) hematogenous dissemination leading to primary septic arthritis. The 13 patients described in this report are all thought to represent septic arthritis due to dissemination.

Although we are in the fourth decade of the antibiotic era, H. influenzae remains high on the list of those pathogenic organisms which produce serious morbidity and mortality. Invasion of the bloodstream, generally from a primary focus in the nasopharynx or middle ear, is rapidly followed by severe, often fulminating illness. In approximately 10% of the patients in this study, antibiotics had been given for early mild symptoms preceding systemic evidence of infection. The antibiotics generally employed in this situation seldom do more than suppress clinical features of disease such as arthritis, pneumonia and meningitis that later becomes apparent. In this way, injudicious antibiotic therapy may interfere with the establishment of a specific diagnosis by culture.

It may not be an incidental finding that three of the eight patients with arthritis seen in the past two years were less than six months of age. Experience recently has been reported from this hospital involving Hemophilus infection in very young infants.[6] Infection with this organism is rare in infants under four months of age. This has been related to the bacteriocidal activity against this organism which is present in the blood of young infants and their mothers and in children over four years of age. This activity was quite low in the blood of the mother of the second patient presented and virtually absent in the 9-month-old infant. It is possible that a survey of the adult population for this antibacterial property today would yield a different result from that reported in 1933.[7]

In management of these infections, the need for prompt diagnosis and intensive treatment is worth emphasis. Blood specimens, joint fluid and cerebrospinal fluid should be obtained at the time of admission from all children in whom a diagnosis of suppurative arthritis is entertained. It is advisable to obtain two or more blood cultures prior to the institution of therapy. Preferably 10 ml. of blood should be cultured and aerobic and anaerobic incubation of blood specimens should be routine. Centrifuged sediments of the cerebrospinal fluid and joint fluid always should be examined by gram stain as well as cultured.

The initial selection of antibacterial agents for the treatment of suppurative arthritis is based on several factors including the age of the patient, the type of organisms seen on gram stain of the joint fluid and any history of antibiotic therapy in the preceding ten days. In the presence of a tentative or positive diagnosis of infection with H. influenzae, ampicillin or chloramphenicol are agents of choice. If chloramphenicol is employed, routine monitoring of blood concentrations is recommended in all infants and is mandatory in the very young.[8]

Suppurative infections of the joints require drainage. Open surgical drainage is essential for infections of the hip joint.[4] Influenzal infections of other joints usually can be drained adequately by arthrocentesis. In many patients only one or two joint aspirations are necessary; repeated arthrocentesis is required occasionally. Elevation of the affected limb, splinting, local heat and early physical therapy may be helpful adjuncts to therapy.

Summary

Experience with serious infections due to Hemophilus influenzae from 1959 to 1966 at the Jackson Memorial Hospital is reported. A total of 178 patients were observed. The total number of patients per year with serious influenzal infections has not changed, but a change in the pattern of systems involved is noted. There has been a recent increase in the numbers of patients with septic arthritis and the number of patients

with meningitis has decreased. Only one patient with epiglottitis has been seen. Thirteen patients with septic arthritis due to H. influenzae are described.

References

1. Weaver, J. B., and Sherwood, L.: Hematogenous Pyarthrosis Due to Bacillus Haemophilus Influenzae and Corynebacterium Xerosis, Surgery 4:908-913 (Dec.) 1938.
2. Gessner, I. H.: Suppurative Arthritis Due to Hemophilus Influenzae, J. Maine M. A. 49:137-139 (Apr.) 1958.
3. San, J. M.: Combined Pyarthrosis, Meningitis and Septicemia Due to Hemophilus Influenzae, Type B, J. Florida M. A. 51:160-161 (Mar.) 1964.
4. Samilson, R. L.; Bersani, F. A., and Watkins, M. B.: Acute Suppurative Arthritis in Infants and Children; The Importance of Early Diagnosis and Surgical Drainage, Pediatrics 21:798-804 (May) 1958.
5. Nelson, J. D., and Koontz, W. C.: Septic Arthritis in Infants and Children, A Review of 117 Cases, Pediatrics 38:966, 1966.
6. Comer A. M ; Connor. J. D., and Nyhan, W. L.: Systemic Infection with Hemophilus Influenzae in Very Young Infants, J. Pediat. 70:539, 1967.
7. Fothergill, L. D., and Wright, J.: Influenzal meningitis; Relation of Age Incidence to Bactericidal Power of Blood Against Causal Organism, J. Immunol. 24:273-284 (Apr.) 1933.
8. Nyhan, W. L.: Measurement of Concentrations of Chloramphenicol in Blood. J. Pediat. 67:1174-1175 (Dec.) 1965.

Dr. Nyhan, P. O. Box 875, Biscayne Annex, Miami 33152.



Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is **PERITINIC®**

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064

Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q. 4 h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA SINUTAB® FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

WC WARNER-CHILCOTT Morris Plains, N.J.

Medicine in St. Augustine During The Spanish Period

William M. Straight, M.D.

When Don Pedro Menéndez de Avilés stepped ashore in September 1565 to found St. Augustine (Fig. 1), he brought with him two surgeons, five barbers and an apothecary with "a box containing medicine for the curing of the sick."[1] In the centuries that followed, however, St. Augustine was to be without a physician or surgeon for periods of time on several occasions. Thus, in July of 1582, Governor Pedro Menéndez Marqués wrote to the King that he had been ill for nine months, having become paralyzed from going into the swamps and woods after the Indians of Guale (Coastal Georgia, particularly St. Catherines Island) and Santa Elena (Port Royal, South Carolina), and that since there was no physician or medicine in the colony, he feared he would not be cured "if the illness ripens."[2]

Before we go into the medical aspects of Spanish Florida, let us take a look at colonial St. Augustine and the everyday life of the people.

The Menéndez expedition was in answer to France's challenge of the Spanish title to Florida, whose limits eventually were Port Royal Sound in the north and the Apalachicola River in the west.[3] Fort Caroline, established by the French in 1564 near present-day Jacksonville, also endangered the Spanish treasure fleets that sailed along the east coast of Florida.

Immediately upon landing, Menéndez began St. Augustine and its fortification simultaneously in a large dwelling of an Indian village on the present site of Nombre de Dios Mission. He then proceeded to destroy the French soldiers at Fort Caroline and at Matanzas Inlet.[4]

The location of St. Augustine in the Indian village, and subsequently on Anastasia Island, ended in 1570 when the town was moved to its present site and the fort built separately nearby. Menéndez also established another fortified settlement, Santa Elena, at Port Royal Sound. St. Augustine developed exclusively as a military outpost and almost all the settlers were soldiers, their wives and children. It served also as a rescue station for mariners shipwrecked along the coast as far north as present South Carolina.[5]



Fig. 1. — Don Pedro Menéndez de Avilés stepped ashore to found St. Augustine, September 1565.

Dr. Straight is an instructor in the history of medicine, University of Miami School of Medicine, Miami.
Presented April 19, 1968 at the University of Florida College of Medicine, Gainesville.

St. Augustine's layout followed the decree of 1573 for towns in Spanish America. By 1586, a grid of four north-south streets and four east-west streets clearly delineated nine city blocks located south of the present plaza. To the north the land was completely vacant. The inhabitants, 150 soldiers and their families, lived in flimsy wooden houses with palmetto-thatched roofs. No wall surrounded the town to protect the people but a wooden watchtower on Anastasia Island was constantly manned to warn of approaching vessels.[6]

It was the sighting of this watchtower that led Sir Francis Drake to sack and burn St. Augustine in 1586. The Spanish began rebuilding immediately and concentrated the garrison wholly in St. Augustine, evacuating Santa Elena.[7]

By the turn of the 17th Century, St. Augustine was still a primitive settlement. The dirt streets became muddy whenever it rained, and some were flooded by high tides. Domestic animals roamed the streets freely. In 1598 there were some 120 flimsy palmetto-thatched houses.[8]

Governor Gonzalo Méndez de Canzo improved St. Augustine during his administration (1597-1603). He established the plaza, a public market, weights and measures, a mill and a hospital. He roofed the church with shingles and built a house for himself facing the plaza. This house was later purchased to serve as the governor's official residence. More important was the firm decision that the settlement would be maintained and would not be moved to Port Royal Sound as some had advocated.[9]

Almost everyone in St. Augustine was in government employ as a soldier or as a government official. Their clothing was imported from Mexico either as the finished product (hats, breeches and stockings—the latter of English wool) or were made (coats, shirts, underwear) from yard goods also imported from Mexico. The diet of the people consisted of corn, beans, flour, pumpkin, lettuce, garlic, radishes, greens, peaches, pomegranates and oranges. Meat was extremely scarce at first and usually imported; later it became some-



Fig. 2. — St. Augustine as pictured by Arnoldus Montanus, 1671.

what easier to obtain as ranches developed in the rich back country near present-day Tallahassee. Meantime, the chief protein came from fish, which could be had in abundance.[10]

St. Augustine was the base for the Franciscan friars who consolidated Spanish rule by converting the Indians to Christianity. In 1587 missions began dotting coastal Georgia and North Florida and this was not halted by Indian revolts in 1597, 1647 and 1655. Accompanied by soldiers, the missionary conveyed the impression of power. This joint military and religious activity was a most natural procedure since Spanish royal authority comprised both secular and ecclesiastical jurisdictions.[11]

By 1668 England had become the chief rival of the Spanish in Florida. That year pirate Captain John Davis (alias Robert Searles) sacked St. Augustine but could not take the wooden fort, the ninth since 1565. Since he did not burn the city, the Spanish believed he would return to hold St. Augustine and raid their shipping along the Florida coast. This spurred the authorization in 1669 to build an adequate stone fortification in Florida. Another stimulus for this construction was the English settlement of Charleston in 1670, which lent credence to the Spanish suspicion of an English design against Florida.[12]

As the building of present Castillo de San Marcos (1672-1696) neared completion, stone was made available for private construction in the city. The poverty of the people, however, prevented the widespread use of this material. Thus in 1702 only 16 houses were made of stone and one of these was the governor's residence. That year the English, led by Governor James Moore, besieged the Castillo unsuccessfully and upon withdrawal set St. Augustine afire.[13] Under this Governor, the British ravaged the missions across North Florida, destroying them during the early years of the 18th century.

St. Augustine was slow to rise from the ashes. By 1713 only the governor's residence had been reconstructed, and ordinary residents used straw and scorched boards to shelter themselves. New and permanent houses did go up, however, and by 1740 there were 300 of them for the 2,062 people residing in the city. When the Spanish turned Florida over to Great Britain in 1763, the population of St. Augustine numbered 3,000 and there were 124 stone, 140 tabby and 78 wooden houses, a total of 342.[14]

The British soldiers destroyed the flimsier houses in St. Augustine to obtain scarce firewood, but the good buildings were improved with the addition of second stories, fireplaces, chimneys and glazed windows. In addition, the Loyalist refugees during the American Revolution built many huts. In 1784, when Florida reverted to Spain, 110 of some 277 houses were considered uninhabitable.[15]

A count in 1788 yielded 1,000 residents and 114 stone, 19 tabby and 133 wooden houses in St. Augustine, a total of 266. About 100 wooden structures were mere shacks, makeshifts during the hectic Loyalist Migration.[16]

When Spain ceded Florida to the United States in 1821, the population in St. Augustine numbered 2,000 and the houses 300. There were also 2,000 persons living in plantations in the countryside. About half of the population were slaves.[17]

The restless sea that pounds the sandy coast was a chief source of food for the people of St. Augustine, and at times it brought other benefits. Thus, the first physician to remain with the colony for a considerable length of time, Juan de LeConte, was cast on the beach at Santa Elena when his ship, El Principe, was driven ashore in a storm about 1579.

Initially, LeConte was a prisoner and served as physician, surgeon and barber in return for his lodging, rations and clothing. In 1586 he was officially allowed to occupy the position of surgeon in the Florida garrison with a salary of four ducats monthly. In 1602, having served "more than 23 years" he approached the governor for permission to return to Spain or an increase in pay to 40 ducats as he was "old and tired and cannot support himself with the four ducats he received every month and the ration of an ordinary private." The governor, being unable to increase his salary and unwilling to permit his only physician-surgeon to leave the colony, encouraged him to petition the king directly and wrote a commendatory letter to the king on his behalf. In the letter the governor notes that he had a "wide knowledge in the art of medicine," and that "if God, our Lord, had not sent him to this garrison, men would die as animals." It is further noted that he cared for the soldiers, slaves, laborers, women and children. The governor stated, "A more competent person could not be secured for a thousand ducats."[18] Having read the letter from the governor to the king, LeConte increased his salary request by ten fold. In 1603

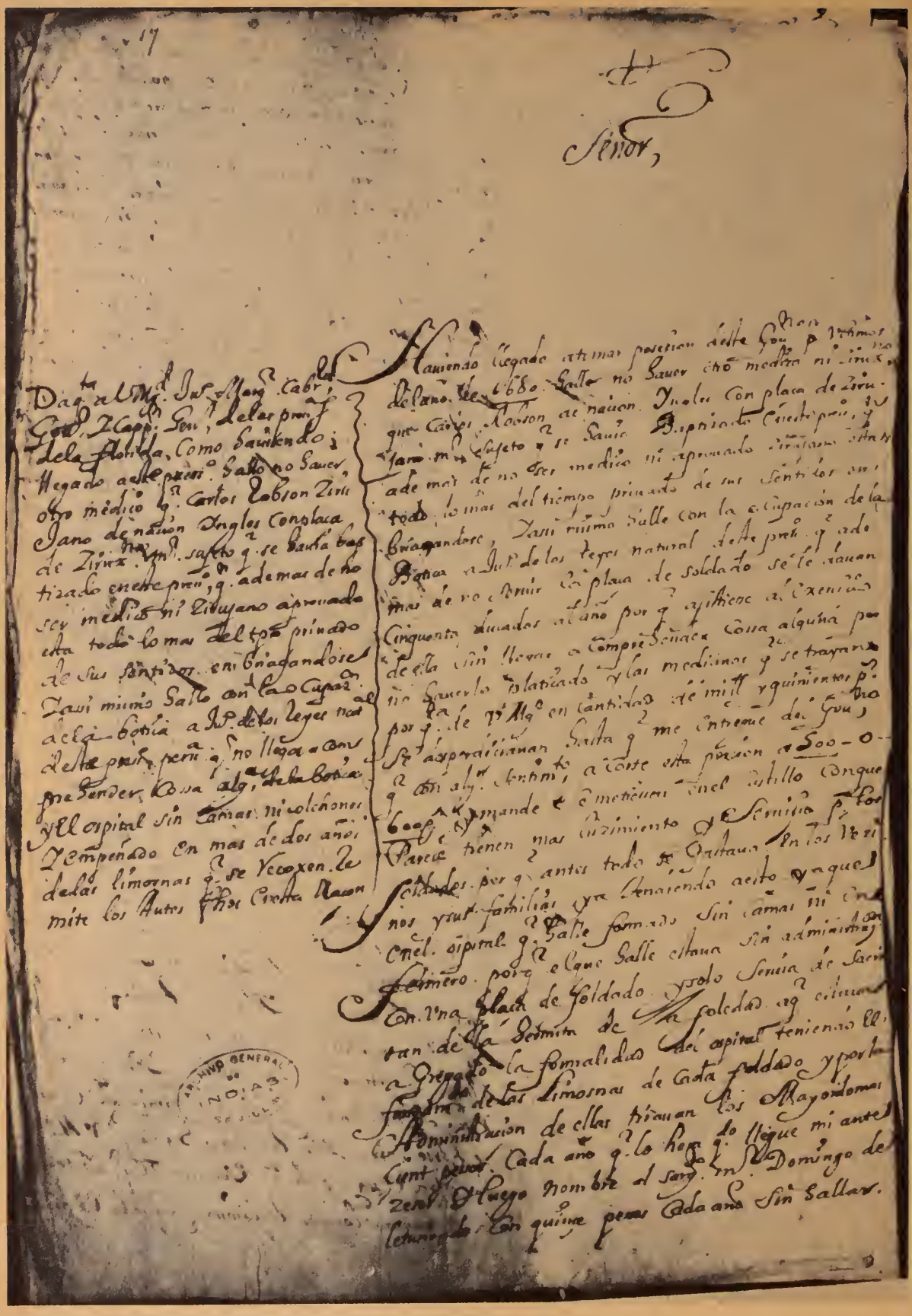


Fig. 3. — Page of Spanish manuscript dealing with Carlos Robson, April 30, 1685.

the crown authorized the governor to increase LeConte's salary—not ten fold as requested by the surgeon, but only to 10 ducats.[19]

At other times in the history of St. Augustine, the populace had to depend upon physicians and surgeons of doubtful value. Thus, on April 30, 1685, Governor Cabrera writing to the Crown states (Fig. 3), "When I took possession of this governorship in 1680 the only physician or surgeon here was Carlos Robson, of English nationality, who held the position of *cirujano mayor* (chief surgeon) and who had been baptized in this garrison. Not only is he not a physician or a qualified surgeon, but also he is deprived of consciousness most of the time by being drunk."[20] Again in August of 1739 another governor writes to his superior in Habana, "Although we have also great need for a physician, if there is not a competent one to be found, we will manage with the *cirujano* of the garrison who, were he not so taken by *aguardiente* (rum), is not bad, but everybody refrains from calling him."[21] This same governor two years prior had written his superior in Cuba urging him to coerce a physician *(medico)* to come to St. Augustine pointing out that previous efforts had been unrewarding. He goes on to state, "Although I consider that there will not be a man of average intelligence who will consent coming here, unless Your Lordship works his authority toward this end.[22] Twenty years later a parish priest writing to the secretary of state for the Indies states, "No less harmful is the damage experienced by the lack in this garrison of a skilled physician or surgeon, seemingly an irremediable and most harmful omission for these poor dwellers, due either to the unwillingness of individuals educated in this profession or to the limited salaries assigned to them, that they do not overcome the horror that the mention of Florida causes in everyone."[23]

Not only were the inhabitants of St. Augustine injured by the incompetence or drunkenness of their surgeons, but also on at least one occasion a surgeon incited a pirate attack on the city. In 1668 Governor Francisco de la Guerra y de la Vega "instigated by feminine gossip and meddling treated the French surgeon of the garrison, Pedro Piques, badly and even slapped him." He then discharged him and refused to give him 200 pesos in accrued pay for his services during the previous two years. The governor put him on a ship bound for Habana. The ship was captured by the English pirate, John Davis, to whom Piques, thirsting for revenge, revealed the condition of St. Augustine's defenses, prompting the pirate to descend on the city at 1:00 A.M. on May 29, 1668. The pirates swarmed through the streets, catching the residents asleep. Hearing the commotion, the residents emerged from their houses and some were shot or knifed to death as they fled to the protection of the woods. The pirates, however, were repulsed in their assault on the fort. With the advent of daylight, the pirates systematically looted the homes and churches and boarded a ship in the harbor. On June 5th they sailed away.[24]

Another medical man who indirectly added to the troubles of St. Augustine was Dr. Henry Woodward. This young "chirurgeon" from North Carolina had gone to live with the Indians at Santa Elena and there was captured by the Spanish and taken to St. Augustine. In St. Augustine as a "willing prisoner" he lived with the parish priest, professed catholicism and served as surgeon for the presidio. He escaped with John Davis during the same raid and later returned to Charleston, S. C., where he was highly influential in inducing the uncommited Indians from giving their allegiance to the Spaniards.[25]

In addition to physicians and surgeons, the medical needs of the people were met by barbers, apothecaries, nurses and midwives. For example, at the muster of the Florida garrison in St. Augustine in 1578, "There was present Hernando de Segovia, barber, a native of Merida, who appeared with his sword, buckler and case of instruments for making cures."[26] Apothecaries were always present in the colony, but at times there were no drugs available, as in November 1674.[27] As early as 1537 the Spanish king had put out an order that the physician could not dispense his own medication, for this was the province of the apothecary.[28] A ruling of the Crown also provided for a deduction from the soldier's pay to cover the cost of drugs and medicines he might require. Although the drugs were usually furnished by the Crown, apparently at times they were obtainable from other sources. In June of 1813 a resident of St. Augustine requested permission to sell certain medicaments such as camphor, alum, cream of tartar, manna, cathartic salt and jallap which he had in his possession and which were scarce in the town.[29]

The nursing of the sick was carried out by convicts or a soldier who served as nurse for the hospital and sexton for the hermitage of La Sole-

dad, to which the hospital was initially attached. At times a slave was assigned to make the beds, cook for the patients and keep the hospital clean. The first such "housekeeper" of record was a royal slave, Maria Joijo.[30]

Midwives are mentioned in St. Augustine first on April 8, 1744,[31] and the note is made that they were permitted to administer baptism if the need were urgent and a priest not immediately available. The names of a number of midwives appear in the registry of baptisms of the St. Augustine Parish. As we have previously noted, the doctors of St. Augustine cared for women, but it is not known whether they performed deliveries.

As early as 1541, Emperor Don Carlos issued an order that in all Spanish and all Indian villages under the control of Spain, hospitals were to be opened where the sick poor could obtain medical attention. This edict was followed in 1573 by another put forth by Phillip II that hospitals for poor and noncontagious patients were to be built near the churches and managed by the church and another hospital for contagious diseases was to be built away from the village in the highest place.[32]

Prior to the advent of the official hospital in St. Augustine, the sister of Governor Pedro Menéndez Marqués, Dõna Catalina Menéndez, cared for the ill soldiers in her home and "spent from her estate in providing treatment to ill soldiers."[33]

The first record we have of a hospital in St. Augustine (Figs. 5 and 6) is a letter from Governor Gonzalo Méndez de Canzo to the Crown dated Feb. 23, 1598, in which he states that when he arrived in 1597 a hospital was being formed in conjunction with the Hermita de Nuestra Señora de La Soledad (the Church of Our Lady of Solitude). Canzo states that had the hospital not been in operation during the summer of 1597 many soldiers, Indians and Negro royal slaves would have died of the epidemic fever. He then tells the Crown that the cost of founding the hospital had exceeded the amount of contributions by more than 500 ducats (a familiar story even in this day) and he petitioned the Crown for financial support and for the assignment of a female Negro royal slave to make the beds, cook for the patients and keep the place clean. To cover the cost of operation, the king was asked to supply 500 ducats annually.[34] There is little description of this hospital but it is presumed that it was of thatch construction and that the beds consisted of



Fig. 4. — The sea brought tragedies and blessings as well.

pallets on the floor (wooden bedsteads were introduced in the 18th century).

This, the first hospital within the present limits of the continental United States, served until 1599 when a fire destroyed the Franciscan convent and it became necessary to house the missionary priests in the Church of Our Lady of Solitude, where the hospital was located.[35]

There now being no place where the sick soldiers and citizenry could be cared for, in January 1600 Governor Canzo "Founded at my expense a house of boards for use as a hospital . . . with its rooms in the attic and having beds with their mattresses, blankets, sheets, and pillows for the stated purpose that all poor and sick people may seek shelter by going to it." This palmetto-thatched hospital of six beds (so arranged about an altar in the center of the room that the patients might observe mass without leaving their beds) was dedicated to "The Lady Santa Barbara." To cover the cost of operation of the hospital, the king supplied 500 ducats annually, and each soldier had deducted from his pay 12 reales annually; the 2½ reales daily ration of the soldier was turned over to the hospital for each day spent in confinement. In addition to this, alms were solicited and farmers were requested to donate foodstuffs. The physicians and surgeons of the garrison were instructed to attend the patients and the medicines were provided by the king.[36]

In 1605, the Franciscan convent having been rebuilt and the Church of Our Lady of Solitude having been repaired, enlarged and freed from the danger of fire, Governor Pedro de Ibarra, Canzo's successor, moved the hospital of Santa Barbara and the patients back to the original hospital. He also had some unpleasant things to say about the location of the Santa Barbara Hospital. He stated that of six patients who had been there three had died and the other three would never recover due to the unhealthy site chosen by Canzo.[37]

In 1657 there were apparently two hospitals in operation to care for the 300 Spanish residents and an unstated number of Indians. These are described as "a royal hospital dedicated to Nuestra Senora de la Soledad, . . . another hospital for curing the poor who are sick, . . ."[38] The pirate John Davis (1668) sacked the hospital and shortly after his attack the governor sent an urgent request to Mexico for quantities of cloth for sheets and mattresses and other small items for the hospital.[39]

In May of 1682, Governor Cabrera, feeling that the Parish of St. Augustine had not managed



Fig. 5. — The first hospital, a lean-to against the wall of the Hermita de Nuestra Señora de La Soledad, 1597.

the hospital well, decided to ask the Order of San Juan de Dios[40] to take over the administration of the royal hospital. This lead to conflicts with the parish and the Franciscans, both of whom feared that more priests would move in to share the meager alms. Being unable to resolve the conflict, Cabrera provided that a hospital be built on another site which would be supported with a share of his income and with the deductions from the soldiers. This left the parish with a hospital but no revenues. Until the new hospital was opened, the priests of San Juan de Dios would serve as both surgeons and apothecaries proceeding in the manner as previous surgeons and apothecaries had proceeded. The temporary arrangement seems to have provided for the surgeon and apothecary to prescribe treatment outside the hospital for sick soldiers, which treatment would be administered in the hospital in the Church of Our Lady of Solitude by the parish-controlled nurse.[41]



Fig. 6. — A palmetto-thatched "house of boards" with six beds about an altar.

In the siege of 1702 the forces of Governor James Moore of South Carolina burned all of St. Augustine except the church of Our Lady of Solitude, the adjacent hospital and some 20 houses.[42] In the years that followed the hospital continued to be supported by deductions from the salary of the garrison and even one peso monthly from the meager remuneration given to convicts and slaves for their work.[43]

The parish priest, Juan José Solana, describes the St. Augustine Hospital in April of 1759 as the "newly rebuilt" former residence of Francisco Menéndez Marqués, deceased accountant of Florida. He states, "It has two large rooms, one on the ground level, the other upstairs, each with a capacity of twelve beds. There are two interior rooms downstairs, reserved for elderly persons. There is a masonry kitchen roofed with boards. In a room in the kitchen live two convicts who care for the sick. The hospital has a lot so spacious that medicinal herbs could be planted in it." In the same letter Solana gives us an insight into the operation of the hospital. He states, "The almost complete destitution experienced by the poor patients deserves no little attention from the pious concern of Your Most Illustrious Lordship (Bishop of Cuba). This hospital receives every month 500 reales deducted from the soldiers, and one real a day from the hospitalized patients. Yet due to the lack of an individual employed ex-

clusively to take care of the patients there is experienced so much carelessness in temporal and spiritual matters that it would cause compassion in the least compassionate heart and even in the most tyrannical. I propose that the governor and the Bishop, or his vicar, elect a major-domo who has demonstrated inclination toward compassion, with a salary equivalent to that of a gunner, a lieutenant, and a fusilier combined, and that one, two or as many convicts as necessary, be subject to the major-domo to attend to the urgencies and needs of the patients."[44]

In the remainder of this paper we will discuss the various illnesses recorded as occurring in St. Augustine and some of the therapies used. Seldom in the archival material thus far studied is there mention of specific remedies, therefore we will cite from the writings of the contemporary physicians, Monardes and Francisco Hernández, treatments used during this period.

The accounts of Florida in the 16th and 17th Centuries are glowing in the best Chamber of Commerce tradition. Thus a geography book of 1688 states, "The area of Florida and Carolina is so temperate that men live to the age of 250 years, while the children of five generations are all alive at the same time."[45]

Earlier we have mentioned the first specific illness noted, the paralysis suffered by Governor Pedro Menéndez Marqués. He stated at that time that he had been paralyzed for the previous nine months but was gradually recovering. The next specifically recorded instance of illness was Governor Domingo Martínez who, when returning from an inspection trip, began to vomit blood and, on Nov. 24, 1595, apparently had an exsanguinating hematemesis.[46]

Chills and fever are frequently noted but it is not possible to diagnose the causative illness. Ashburn, a student of epidemic diseases,[47] believes there was no malaria among the Huguenots or the Spanish in the early days of settlement, but that malaria came later with the introduction of slaves. The first mention of quinine appears in a religious book which was published in Spain in 1639 and written by an Augustinian monk by the name of Calancha. We have found no record of quinine being used at St. Augustine during the first or second Spanish period.

A severe epidemic of smallpox was present in the town in 1655. Governor Diego de Rebolledo notes that it has been present for ten months, the Indians and inhabitants had suffered greatly, and that work on the fort was at a standstill.[48] Still other epidemics of smallpox are recorded.[49] We have thus far discovered no evidence that inoculation was used in St. Augustine to fight this disease. On Nov. 10, 1803, the King of Spain dispatched an expedition to bring smallpox vaccination to the new world. In order that they would have fresh vaccine on their arrival they brought along 22 children whom they inoculated at intervals during the trip.[50] There is no record that this expedition visited St. Augustine.

As in other colonial areas, epidemic measles was at least once a highly fatal disease in Spanish Florida. Thus, in 1659 epidemic measles killed 10,000 Indians and many soldiers of the garrison at St. Augustine.[51]

There are many reports of syphilis *(gálico)* and on one occasion this disease incapacitated the mason in charge of the work at Castillo de San Marcos.[52] The specific remedy for this disease according to Monardes was the "holie woodde" now known as guaiacum, a tree found in tropical America. Monardes tells us about the discovery of this medicine: "A Spanyarde that did suffer greate paines of the Poxe, whiche he had by the companie of an indian woman, but his servaunte beyng one of the phisitions of that countrie, gave unto hym the water of Guaiacan, wherewith not only his greevous paines were taken awaie, that he did suffer, but healed verie well of the evill, and moste certainlie . . . it healeth moste perfectly, without turnyng to fall againe, except the sicke man doe returne to tumble in the same bosome, where he tooke the firste."[53]

Because of a custom of continuing a man after he was crippled or ill as a member of the garrison on a "dead pay" status, we have from time to time lists of soldiers specifying their disabilities. A review of these lists reveals such diagnoses as "absolutely blind and deaf; old and habitually ill; habitually indisposed; asthmatic; disuse of a limb due to disease or accident; bent or crooked due to an accident; blind and demented; blind and ruptured; hobbled and ruptured; gouty; palsied (paralysis with a tremor); leg broken by gun shot; paralyzed and short sighted due to organic defect." In the case of an 83-year-old Captain Sebastián López de Toledo the diagnosis is "very exhausted" *(Muy postrado)*.[54] In some instances the diagnosis is easily recognized, as in the case of Sublieutenant Luis García de Mena who was "threatened by tisis (pulmonary tuberculosis), the beginning of which is indicated by the



Fig. 7. — Tobacco, the Timucan remedy for afflictions of the lungs.

blood which he spits when he coughs."[55] On another occasion we are told, "When he dropped anchor in this port *Patrón* (skipper) Matamoros experienced his last hardship, a *sofocación* (suffocation) which followed the labored respiration from which he was suffering, so sudden that he did not have time to receive any sacraments."[56] Possibly this was acute pulmonary edema due to congestive heart failure.

The wonder drug of the day was sassafras which was found in Florida. We are told that it was given to the Huguenots at Fort Caroline by the Indians and the knowledge of it conveyed to the Spanish by survivors of the Huguenot massacre. Barcia tells us it was brought to Seville in 1567. He states that it was a sovereign remedy against "killing oppilation." It also was soothing to the liver and stomach, it would take away the tertian ague and cause long fevers to desist, restored the appetite, cured headaches, chest aches and pains in the side; it caused stones to be passed, induced micturation and menstruation; it cured paralysis, relieved the toothache, cured gout quickly and made the hands benumbed by illness agile. It also soothed the abdomen and relieved motherhood sickness. It promoted fecundity, preserved from plagues and was most useful in all cold humors, protracted illnesses and flatulence.[57] Monardes adds that it was useful in "any maner of Reumes or Runnynges or Windinesse . . . ."[58]

Another remedy to be found in Florida was tobacco. This was useful for many things including headaches, shortness of breath and the treatment of chronic ulcers. The cough and expectoration produced by the tobacco smoke was thought to clear out the lungs and thus help shortness of breath. This remedy, it is said, was learned from the Indians and, indeed, LeMoyne, the Huguenot artist, in one of his drawings shows the Indians inhaling tobacco smoke.[59] (Fig. 7) Monardes also states that it is very useful for the treatment of "olde rotten soares although thei bee cankered." He advises, "Let the sicke man bee pourged with the counsaill of a phisition, and let hym bloud if it bee needful and then take this herbe and piunde it in a Morter, and take out the Joice and put it into the Soare, and then after the maner of a Plaister put the stamped leaves upon it. . . . and this doe once every daie, eatyng good meates, and not exceedyng in any disorder for otherwise it will not profite."[60]

Thus far we have uncovered very little specific information about the practice of surgery in St. Augustine. LeConte, the French barber surgeon who served the colony from about 1579 to about 1630, was certified by the sergeant major of Florida as skillful in "curing effectively all kinds of diseases and wounds . . . from arrows, pikes, halberds, and arquebuses, and broken legs, arms and heads."[61]

In a battle between the Spanish and the Indians on Sept. 3, 1705, Ensign Francisco Ponce de León was shot in the arm, shattering the bone. It was necessary to amputate the arm, but immediately after the amputation Don Francisco died.[62]

In September 1727, Juan Frisonou, chief surgeon of the Florida garrison, certifies that the Governor, Don Antonio de Benavides, had developed "an abscess which has appeared between the two cheeks which fall from the lower part of the coccyx, from which he has acquired some impediment in urinating, some continuous evacuations, fever, and other troubles . . ." The surgeon further states that the governor "cannot be cured in this said garrison for the total lack of medicaments and the necessary instruments."[63]

The governor went to Habana where the physician and surgeon, Carlos del Rey, "found him with a great inflammation in the rectum with a fistula in the rectum four *dedos* deep (72 millimeters), originated from an abscess, which illness was accompanied by other illnesses (such as) obstructions in the glands of the mesentery, . . . the operation on said fistula was performed on him, opening it from the beginning to the end."[64]

Finally, we have uncovered one instance in which the history of St. Augustine may have been changed by the advent of disease. In 1680 Sergeant Major Juan Márquez Cabrera, about whom we have spoken before, became governor. Cabrera was apparently a testy character with a facility for alienating people. This personality trait was aggravated by an illness which is described by a Dr. Francisco Moreno de Alba as "some arthritic pains complicated with a trace of *gálico* (syphilis). The pains are felt in his soft and spermatic parts, which are naturally cold, and a paralytic affection is beginning in the nerves and ligaments, threatening the deadening of a leg, which has a mature and inflammed chronic cutaneous infection, resulting from crusty, well-developed carbuncles, and from his extreme weakness."[65]

In the several years that Cabrera had been governor he had succeeded in alienating the soldiers and officers of the garrison, the Indians, the citizens of the town and the clergy. During the Holy Week of 1687 he went to one of the priests for his annual confession. The priest refused to confess him as did other priests whom he consulted. He boarded a ship ready to sail for Habana ostensibly to inspect the ship but actually intending to go to that city to find a priest who would confess him. As it was considered near treason for a governor to leave his province without the permission of the king, the royal treasurer, who had gone aboard the ship with the governor, exhorted him to change his mind and return to shore. The treasurer pointed out that the colony would be without a governor and, indeed, St. Augustine was direly in need of a governor. He also pointed out that the king and queen would not look favorably upon this breach of his responsibilities. In a fit of anger the governor, it was quoted, replied, "S—t on St. Augustine; the king and queen can go to hell."[66] Perhaps had he not been ill, in addition to having a testy personality, Governor Cabrera would have continued as governor of Florida and the course of history would have been different.

Acknowledgments

The search and translation of the Spanish documents, which are the major source of the information herein presented, was performed by Mr. Luis R. Arana of St. Augustine. This search was supported by U.S. Public Health Service Grant No. 1-RO1-LM-00074-01 awarded to the University of Miami, Miami, Florida.

The illustrations, with the exception of Fig. 2, were drawn by Mr. Newton Randum.

References

1. Eugenio Ruidiaz y Caravia: La Florida, su Conquista y Colonización por Pedro Menéndez de Avilés, 2 vols. (Madrid: 1893), II, 558, 560, 565.
2. Stetson Collection (hereafter SC): Archivo General de Indias (hereafter AGI) 54-5-16/27, Governor Pedro Menéndez Marqués of Florida to the crown, St. Augustine, July 6, 1582, folio 2.
3. SC: AGI 58-1-26/38, Governor Pablo de Hita Salazar of Florida to the crown, St. Augustine, August 24, 1675, folios 4, 6.
4. Woodbury Lowery: The Spanish Settlements Within the Present Limits of the United States, Florida 1562-1574 (New York: 1905), 103, 108, 158, 168-177, 189-199.
5. Verne E. Chatelain: The Defenses of Spanish Florida 1565-1763 (Washington: 1941), 15, 21, 44, 46-47; Charles W. Arnade: Florida on Trial 1593-1602 (Miami: 1959), 77-78.
6. Chatelain: The Defenses . . ., 30, 129 note 4; the Boazio map of St. Augustine and key in Julian S. Corbett, Drake and the Tudor Navy, 2 vols. (London: 1912), II, 56.
7. Chatelain: The Defenses . . ., 50, 51.
8. Arnade: Florida on Trial . . ., 8, 9.
9. Arnade: Florida on Trial . . ., 8, 9, 90; SC: AGI 54-5-9/47, Governor Pedro de Ibarra of Florida to the crown, St. Augustine, Jan. 8, 1604.
10. Arnade: Florida on Trial . . ., 9; Charles W. Arnade: "Cattle Raising in Spanish Florida 1513-1763," Agricultural History, XXXV, No. 3 (July 1961); SC: AGI 58-2-3/58, The royal officials of Florida to the crown, Florida, September 14, 1713, f. 4.
11. Michael V. Gannon: The Cross in the Sand—The Early Catholic Church in Florida 1513-1870 (Gainesville: 1965), 38-43, 47, 54, 56-58, 61-64; C. H. Haring: The Spanish Empire in America (New York: 1947), 179-182.
12. Chatelain: The Defenses . . ., 62, 151 note 18.
13. Albert C. Manucy: The Building of Castillo de San Marcos (Washington: 1942); Charles W. Arnade: The Siege of St. Augustine in 1702 (Gainesville: 1959); Mark F. Boyd, Hale G. Smith, and John W. Griffin: Here They Once Stood—The Tragic End of the Apalachee Missions (Gainesville: 1951); SC: AGI 54-5-12/102, Governor Diego de

TABLE 1.—GROWTH OF ST. AUGUSTINE DURING THE SPANISH PERIOD

Year	Total Population	Number of Houses	Reference
1598	625	120	8
	(Present Castillo de San Marcos built 1672-1696)		
1689	1,444	——	13
1702	1,500	172	13
1740	2,062	300	14
1763	3,000	342	14
	(Florida belonged to Britain 1763-1784)		
1788	1,000	266	16
1821	2,000	300	17
	(Florida belonged to the United States after 1821)		

Luis Rafael Arana



Aided by the G.I. Bill of Rights, Luis Arana obtained a B.A. degree in history at the Interamerican University, San German, in his native Puerto Rico. He attended law school briefly but dropped out to go to work for the National Park Service in San Juan. Having been transferred to St. Augustine, he obtained an M.A. degree in Latin American history from the University of Florida.

He has become widely known in historical circles as a skilled Spanish paleographer. During the past 18 months, he has diligently searched the available archival material uncovering (much of it for the first time since its inscription) the material recounted in this article and is now Chief Park Historian at Castillo de San Marcos, St. Augustine.

Newton Randum



A native of Washington, D. C., Newton Randum could draw before he could talk. He obtained his first formal instruction in art at the Corcoran Gallery in Washington. This was followed by a sojourn in Paris as an impecunious art student who "looked at a franc like a Frenchman did." During this period he studied medical illustration at the Sorbonne and poster art with the celebrated Jean Carlu.

He returned to this country and worked for a number of years with the Smithsonian Institution and the Department of the Interior preparing displays, models and dioramas. Mr. Randum is the artist who drew the cover illustration and all but one of the illustrations for this article.

Quiroga y Losada of Florida to the crown, St. Augustine, June 8, 1690; SC: AGI 58-1-28/66, Governor Francisco de Córcoles y Martinez of Florida to the crown, St. Augustine, Aug. 13, 1709.

14. Albert Manucy: The Houses of St. Augustine (Notes on the Architecture from 1565 to 1821, (St. Augustine: The Historical Society, 1962), 25-28, 33; East Florida Papers (hereafter EFP): series 37, letter No. 197, Governor Manuel de Montiano of Florida to Governor Juan Francisco de Güemes of Habana, St. Augustine, May 9, 1740.
15. Manucy: The Houses . . ., 34, 35, 38-39, 41.
16. Manucy: The Houses . . ., 43, 46.
17. Manucy: The Houses . . ., 10, 45.
18. SC: AGI 54-5-17/68, Master Juan de Laconte to the crown, St. Augustine, May 4, 1611, ff. 4, 5, 12, 14; Woodbury Lowery: Florida Manuscript, (hereafter WL), vol. 4: AGI 54-5-9, Governor Gonzalo Méndez de Canzo of Florida to the crown, St. Augustine, May 22, 1602, f. 2.
19. SC: AGI 86-5-19 (SD 2528), Crown to the governor of Florida, Valladolid, March 22, 1603, ff. 278-278v.
20. SC: AGI 54-5-15/17, Governor Juan Márquez Cabrera of Florida to the crown, St. Augustine, April 30, 1685, f. 1.
21. EFP: series 37, letter No. 154, Governor Manuél de Montiano of Florida to Governor Juan Francisco de Güemes of Habana, Florida, Aug. 16, 1739, f. 178.
22. EFP: series 37, letter No. 24, Montiano to Güemes, Feb. 15, 1738, f. 63v.
23. SC: AGI 86-7-21/41, Parish priest Juan José Solana of St. Augustine to the Secretary of State for the Indies, Julián de Arriaga, St. Augustine, April 9, 1760, f. 33.
24. North Carolina Collection 682 (bereafter NC): AGI 54-5-18/73, Sergeant Major Nicholas Ponce de León of Florida to the crown, St. Augustine, Aug. 6, 1668; SC: AGI 54-5-18/70, Accountant Juan Menéndez Marqués of Florida to the crown, Florida, July 4, 1668.
25. Medical Men and Medical Events in Early St. Augustine, J. Florida M. A., 39:116 (August) 1952.
26. Jeanette T. Connor: Colonial Records of Spanish Florida. 2 vols. (DeLand: 1925, 1930), II, 137.
27. SC: AGI 54-5-19/19, Captain Francisco de Reina of Florida to the crown, St. Augustine, Nov. 17, 1676, f. 1.
28. Francisco Guerra: Historiografía de la Medicina Colonial Hispanoamericana, (Mexico: 1953), 32.
29. EFP: series 412, Cabildo Records, f. 51.
30. SC: AGI 54-5-16/106, Ensign Bartolomé López Gavira to the governor of Florida, St. Augustine, [Sept. 12, 1600], f. 3; SC: AGI 54-5-15/17, f. 1; SC: AGI 86-7-21/41, f. 34.
31. St. Augustine Parish Registers: Group IV, Baptisms 1735-1763.
32. Guerra: Historiografía, 30.
33. SC: AGI 53-1-6/42, Council of the Indies to the crown, Madrid, Nov. 3, 1629, f. 1.
34. WL 4: AGI 54-5-9, Governor Gonzalo Méndez de Canzo of Florida to the crown, St. Augustine, Feb. 23, 1598, ff. 10-11. SC: AGI 53-1-6/8, Council of the Indies to the crown, Madrid, Aug. 16, 1598, f. 4.
35. SC: AGI 54-5-9/32, Governor Gonzalo Méndez de Canzo of Florida to the crown, St. Augustine, Feb. 28, 1600, f. 1v.
36. SC: AGI 54-5-9/32; SC: AGI 54-5-15/17, ff. 17-23; SC: AGI 54-5-9/64, Governor Pedro de Ibarra of Florida to the crown, St. Augustine, Dec. 26, 1605, f. 6.
37. SC: AGI 54-5-9/64, ff. 5-6.
38. WL 8: Juan Diez de la Calle, Noticias Sacras y Reales de los Dos Imperios de las Indias Occidentales de la Nueva España, 2 vols. (1659), f. 4.
39. NC: AGI 58:2-2/14, Marqués de Mancera, Viceroy of New Spain, to the crown, Mexico, April 20, 1669, ff. 50, 73.
40. The Order of San Juan de Dios was founded in Granada in 1540. Initially, its members provided for the care of the poor sick, but during the 17th and 18th Centuries they became the medical corps of the Spanish armies and were appointed to administer hospitals throughout Spain and Spanish America. At the close of the 18th Century they numbered 2,915 religiosi serving in 281 hospitals (Spanish Influence on Progress of Medical Science, London, Wellcome Foundation, 1935, p. 43). Members of this Order served as physicians, surgeons, apothecaries and nurses (Francisco Barado, Museo Militar—Historia del ejército español, 3 vols. [Barcelona: c. 1883], III, 578).
41. SC: AGI 54-5-15/17, ff. 6-9, 25-26, 30-38, 45-49, 50-59.
42. Arnade: The Siege . . ., 57.
the Trihunal of Accounts in Cuba to the crown, Habana, Jan. 10-14, 1752, ff. 154-155.
44. SC: AGI 86-7-21/41, f. 34, 35.
45. Morden: Geography Rectified or a Description of the World, (London, 1688): p. 588.
46. WL 3: AGI 54-5-16, Factor Alonso de las Alas of Florida to the crown, St. Augustine, Jan. 11, 1596, ff. 1, 2-3.
47. P. M. Ashburn: Ranks of Death: A Medical History of the Conquest of America (New York, 1947), p. 117.
48. SC: AGI 58-2-2/2, Governor Diego de Rebolledo of Florida to the crown, St. Augustine, Oct. 24, 1655, f. 1.
49. In 1732, 1740, 1758 and 1814.
50. Arturo P. Prats: Contribution of Spanish Physicians to the Culture and Colonization Effort of Spain in America, Annals Royal National Academy of Medicine 82 (1965), 327-352.
51. SC: AGI 58-2-2/4, Governor Alonso de Aranguiz y Cotes of Florida to the crown, St. Augustine, Nov. 1, 1659, f. 2.
52. EFP: series 37, letter No. 74, Montiano to Güemes, Aug. 8, 1738, ff. 107v-108.
53. Nicholas Monardes: Joyfull Newes Out of the Newe Founde Worlde, 2 vols. (Sevilla: 1574), translated into English by John Frampton, 1577, reprinted Constahle and Co., Ltd. (London: 1925), p. 28.
54. SC: AGI 87-3-12/70, Governor Manuel de Montiano of Florida to the Secretary of State for the Indies, Marqués de la Ensenada, St. Augustine, Jan. 21, 1745, f. 33.
55. EFP: series 37, letter No. 221, Montiano to Güemes, Aug. 30, 1740, f. 302.
56. EFP: series 37, letter No. 255, Montiano to Güemes, Jan. 31, 1741, f. 336v.
57. Andrés González Barcia: Chronological History of the Continent of Florida, Translated by Anthony Kerrigan, (Gainesville: 1951), 145-146.
58. Monardes: Joyfull Newes (Frampton translation), pp. 38-44.
59. Plate XX, Acgros curandi ratio (Method of treating the sick), by Jacques LeMoyne de Morgues in Brevis Narratio eorum quae in Florida Americae provincia Gallis acciderunt, which is part II of Theodor de Bry's Collectiones Peregrinationum in Indian Orientation (Frankfurt: 1941). Brevis Narratio was translated into English by Fred B. Perkins as the Narrative of LeMoyne (Boston: 1875).
60. Monardes: Joyfull Newes (Frampton translation). 83.
61. SC: AGI 54-5-17/68, f. 14.
62. SC: AGI 58-1-28/12, Governor Francisco de Córcoles y Martinez of Florida to the crown, St. Augustine, Nov. 16, 1706, f. 5.
63. SC: AGI 58-1-31/14, Governor Antonio de Benavides of Florida to the crown, St. Augustine, Sept. 28, 1727, ff. 6-7.
64. SC: AGI 58-1-31/14, ff. 15-16.
65. SC: AGI 54-2-19/2, Lieutenant Governor Francisco Manuel de Roa of Habana to Secretary Antonio Ortiz de Otalora of the Council of the Indies, Habana, March 22, 1690, ff. 266-268.
66. Luis Rafael Arana: The Day Governor Cabrera Left Florida, Florida Historical Quarterly, 40:154-163 (Octoher) 1961.

▶ Dr. Straight, 550 Brickell Avenue, Miami 33131.

Dr. Howell Tyson Lykes
Founder of an Empire

James M. Ingram, M.D.

Among the physicians of pioneer Florida were several whose greatest and most lasting achievements lay far outside the field of medicine. Dr. John Gorrie of Apalachicola invented the ice-making machine. His fellow townsman, Dr. Allen W. Chapman, wrote the classic textbook in botany, "Flowers of the Southern United States." Dr. John P. Wall planned Florida's present major highway system, served as mayor of Tampa and excelled as a meteorologist. Dr. Henry Perrine imported to southern Florida from Yucatan many of the plants now considered to be "native" to this state. Dr. Abel S. Baldwin designed Jacksonville's harbor and was elected president of the first railroad connecting Jacksonville and Pensacola. Of these talented Floridians, the physician who practiced the shortest length of time and left the most enduring material accomplishments was Dr. Howell Tyson Lykes of Brooksville and Tampa.

Dr. Lykes was born in Columbia, S. C. on Aug. 25, 1846, the son of Frederick and Margaret Howell (Tyson) Lykes. Frederick's family had immigrated from the German-speaking cantons of Switzerland in the mid-18th Century. Their family estate "Lykesland" in Congaree Township, S. C., was a portion of the land they obtained by royal Bounty Grant from King George II in 1750. The family name was spelled as Liks, Lix, Lyks and in other forms.[1]

In the belief that Margaret Lykes had tuberculosis, the family moved to Florida in 1851, purchasing 500 acres of land at "Spring Hill" west of Pierceville, now called Brooksville.[1] Frederick Lykes, already educated as a teacher, established and built the first school in Hernando County. With foresight, he had brought along orange seeds imported from China, and planted the early seedling orange groves in that area.[2]

Howell Tyson, the third of four children, was five years old when the family moved to Florida. He studied first at home, then in the school at Pierceville. He was an "energetic, quiet and somber" lad, who was by far the best student in his father's school. At an early age he took interest in his father's activities in cotton, timber and cattle.

Barely old enough to serve in the Civil War, he joined the Confederate company commanded by his brother-in-law, Judge Wall. He was captured by Union forces and released in 1865 at Bay Port, Fla.[3] After the war, by unknown impetus, he decided to study medicine. He was graduated from Charleston Medical College in the late 1860's.[4]

Returning to Brooksville, he engaged in an arduous country practice, traveling by horseback over the sparsely settled country to visit patients. Money was not plentiful and bills were more often paid in oranges, potatoes and corn. There was no hospital. Surgery was limited and crude. Few specific drugs were known. As few physicians in that era were willing to do, Dr. Lykes faced honestly the limitations of available therapy and shared the same question as his kinsman,



Fig. 1. — The 109 foot motor schooner Dr. Lykes was built in 1899 for Dr. Lykes and Captain W. H. Towles of Punta Rassa.

Dr. John P. Wall: "Is there any evidence that the average duration of life has been lengthened by our superior skill in the treatment of disease? On the other hand, is there not considerable ground for the belief that thousands of lives have been sacrificed by the exhibition of our remedies?"[5]

After two years of practice, he turned his patients over to another kinsman-by-marriage, Dr. Sheldon Stringer Sr., and channeled his energy and ambition into other pursuits. He first turned to the cedar logging industry, as cedar was much in demand for pencils in America and Europe. Huge cedar logs were cut from the swamps and Indian mounds of coastal Hernando and Citrus counties, and were floated down the Chassahowitzka and Weekiwachee Rivers to the head of Crystal River for milling. Additional tracts of land were acquired along the coast and were converted to pasture after logging was completed.

In 1874, Dr. Lykes, then age 28, married Almeria Belle McKay, daughter of Tampa shipmaster and exporter, Captain James McKay. Two years later, in 1876, on the death of his father, Dr. Lykes inherited Spring Hill and other property. All of the eight Lykes children, a daughter and seven sons, were born at Spring Hill between 1877 and 1888. Their names, in order of birth, were: Matilda McKay; Frederick Eugene; Howell Tyson Jr.; James McKay; Lipscomb Goodwin (Dick); Thompson Mayo; John Wall, and Joseph Taliaferro.

During the decade between 1868 and 1878, the Cuban insurrection against Spain was setting the stage for a boom of the cattle industry in South Florida, and for the good fortune of Dr. Lykes and other cattlemen. Most of the cattle in Cuba were destroyed in the fighting and there was constant demand for restocking of the herds. Dr. Lykes' interests in cattle and land grew. His cattle soon ranged in an area from present Citrus County, over the western part of Hernando, Pasco, Hillsborough and Pinellas counties and as far south as Largo.[2]

It is of incidental interest that the birth of Florida's only set of quintuplets occurred on Lykes property, the "Lykes Lemon Grove," just north of Bay Port in 1860. The mother, Mrs. Joe Goethe, described as "less than average size, and not very robust," was attended by Dr. Sheldon Stringer Sr. The quintuplets, all boys, "were perfectly

formed at birth, but all died in infancy."[6]

Beginning in 1874, Dr. Lykes served two terms in the Florida legislature as senator representing Hernando, Citrus and Pasco counties. Legislative process was evidently more leisurely in that day. The Sunland Tribune of March 1, 1879 reported that the legislature adjourned for three days in order that the members could attend the State Fair at Gainesville. Dr. Lykes was listed as having won three "diplomas" and cash prizes for his "Brahmin cattle" at the fair, proving the presence of Brahma cattle in Florida at that early date.

Until 1880, Dr. Lykes was largely a producer of cattle, which he sold at Tampa or Punta Rassa. Later, in partnership with Captain W. H. Towles of Punta Rassa, he began to export cattle to Havana for sale. Their first two boats were the 109 foot motor schooner, Dr. Lykes (Fig. 1) and the little steamer Fanita. The Fanita had been built by the Vanderbilt family as a private yacht. The bones of her hull can still be found rusting on a sandspit east of Tampa's Seddon Island.[7] In addition to the Lykes cattle, other herds were purchased as far south as Lee County and the Kissimmee River for export.

In 1886 Dr. Lykes built Tampa's first three-story brick building, the Almeria Hotel (Fig. 2). It was built on his wife's birthplace and was named for her. This building, on the northeast corner of Franklin and Washington Streets, is now remodeled and serves as the modern office of Lykes Bros., Inc.

Dr. Lykes was 40 years old at this time, of medium height, slender of build, restlessly energetic, solemn, taciturn and sometimes stern. His eldest son, Fred, recalls, "My father, if anything, was an efficient disciplinarian. Each of us from the time we were five years old had our regular duties to perform that no one else was permitted to do for us. As we grew older our responsibility was increased. He taught us early to act on our own judgement and initiative. If we erred in our judgement there was no fuss or criticism from him. When he was in the house, peace, quiet and harmony reigned." He describes his mother as having "personal charm, sympathetic understanding, patience and spiritual beauty. This home life, inspiration, and business training that we got from our parents at this age has been invaluable to us."[8]

After the disastrous freeze of 1894-1895, which killed most of the citrus groves in the state, the Lykes family acquired an entire section of land and built a new home at Ballast Point, overlooking Hillsborough Bay just south of Tampa. This home now is occupied by a grand-



Fig. 2. — Franklin Street, looking north at Washington Street, about 1890. Dr. Lykes' Almeria Hotel, (right) named for his wife, was Tampa's first three-story brick structure. Sand streets and wooden sidewalks served the center of town.

daughter, Mrs. Chester H. Ferguson, and her family. Just north of the house, where Tampa Yacht and Country Club now stands, Dr. Lykes built a long dock "three steers wide" for the loading of cattle upon ships. Thus he became the only cattle exporter who shipped virtually from his front yard.

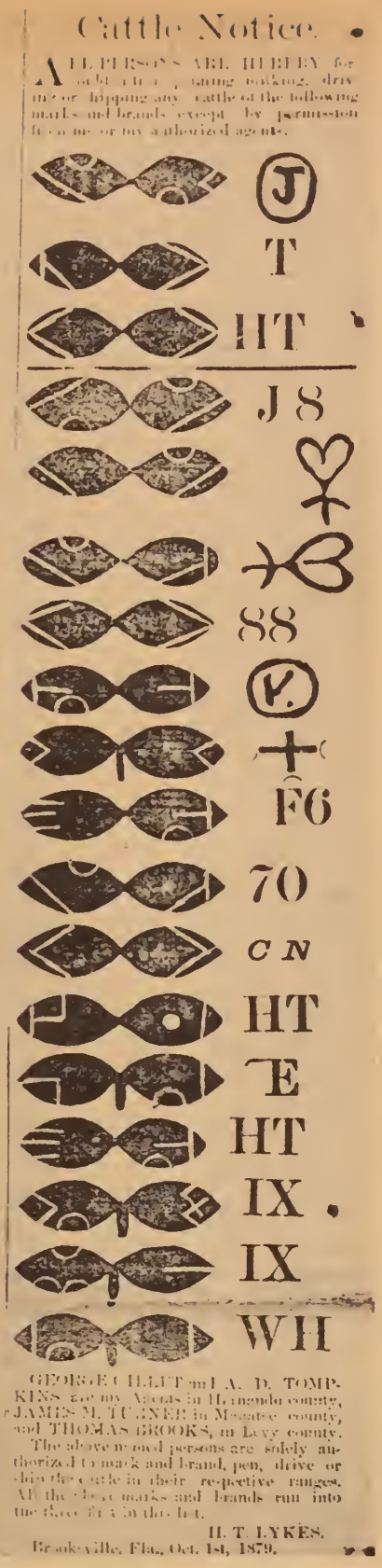
The Tampa Interbay Peninsula in those days was still much in its primitive state. Nature had not been gentle to this land. The entire peninsula, up to present-day Kennedy Boulevard, had been inundated by bay water during Tampa's worst hurricane, Sept. 25, 1848.[9] The devastating drought of 1860 so parched the area that only 3,500 of the 8,000 cattle in pasture there survived.[10] Later a hand-hewn rail fence was built across the peninsula from Hillsborough Bay to Old Tampa Bay, to contain the cattle. The present Bay-to-Bay Boulevard follows the route of this fence.[11] By the time the Lykes family moved to Ballast Point in 1895, H. B. Plant had built his rickety railroad spur to an embryo Port Tampa. There was little else on the Interbay Peninsula except a few cracker shacks, varying numbers of range cows and astronomic numbers of rattlesnakes.

Cattle business was the big business on the West Coast. The Savannah News of Oct. 25, 1879 listed the following shipments of cattle to Cuba: "Ziba King, 6,000 head; Jake Summerlin, 7,000 head; Dr. Lykes, 10,000 head." This trade had a profound effect on the money in use in the area. Both Cubans and Floridians distrusted Spanish bank notes, and had little more respect for the American dollar. They dealt primarily in gold Spanish doubloons, worth $16.80 each. These bright, soft coins were always measured by weighing because they wore easily. McKay and Grismer, respected Tampa historians, each state that for about 20 years "gold Spanish doubloons became more common in Tampa and the cattle country than American dollars."[12,13]

D. B. McKay relates how Dr. Lykes and his inseparable Negro companion-servant, Charlie Johnson, handled this heavy loot.

"A consignment of cattle was loaded on a ship at the Ballast Point docks. The Cuban buyer paid Dr. Lykes the agreed price—enough gold coins to fill an Octagon soap box. Dr. Lykes slept in his nearby camp that night using the box of money with a saddle blanket over it for a pillow.

"Cowboys slept all around him, but he felt no uneasiness—his faithful servant, Charlie John-


Cattle Notice.

ALL PERSONS ARE HEREBY for[illegible] marking, making, driving or shipping any cattle on the following marks and brands except by permission from me or my authorized agents.

J
T
HT
J S
88
V.
F6
70
C N
HT
E
HT
IX .
IX
WH

GEORGE CLUTT and A. D. TOMPKINS are my Agents in Hernando county, JAMES M. TURNER in Manatee county, and THOMAS BROOKS, in Levy county.

The above named persons are solely authorized to mark and brand, pen, drive or ship the cattle in their respective ranges. All the above marks and brands run into the three fork in the hot.

H. T. LYKES.

Brooksville, Fla., Oct. 1st, 1879.

Fig. 3. — Newspapers often carried Cattle Notices, displaying the owners' ear croppings and flank brands. Violators usually responded to reason, but were occasionally shot.

son, was on guard duty day and night ready to do battle with man or beast . . . Charlie was a peculiar figure, much over six feet tall and so knock-kneed that he walked with difficulty. He always rode a frisky little mule and his feet almost dragged the ground."[14] The son of the freed slaves of Dr. Lykes' father, Charlie was an important force in the rearing and training of Dr. Lykes' own sons.

The stockmen, often termed "cattle kings," were the dominant figures of west Florida's most colorful era. The law of the open range prevailed from Palatka to Lake Okeechobee throughout the 19th Century. The Western Plains provided no more thrilling stories of cattle drives, open-range feuds and shootouts than did Florida. Newspapers carried "Cattle Warnings" (Fig. 3) displaying the owners' brands and ear croppings. These warnings usually could be enforced with labor and reasoning, but, when not, with revolvers.

The names of the famous cattlemen were equally picturesque—names like Ziba King of Fort Ogden, Captain John T. Lesley of Fort Brooke and Jake Summerlin, "King of the Crackers." Jake, among others, could handle an 18-foot bullwhip as well as any cowhand (The crack of this whip gave the "Florida Cracker" his nickname). Big stockmen shared the common traits of extreme individuality, hard work and high living. The unbroken flow from Havana of gold coins, fine goods and aged spirits made their way of life profitable and pleasurable. Dr. Lykes fitted well in this company.



Fig. 4. — Dr. Howell Tyson Lykes on the lawn of his home about 1894.

Such a full life was not allowed to interfere with the training, education and discipline of the seven sons. As each achieved his early teens, he was sent during the summers to learn the family business as a cowboy, hotel clerk or deckhand. Their activities were kept under the stern eye of the doctor. (Fig. 4) His counsel was readily available, pertinent and succinct. It usually ended with the same phrase, "Stick together whatever you do, and take care of your sister." The maturing and molding together of this strong family were greater achievements for Dr. Lykes than were any of his economic successes.

In time, the seven sons and daughter "Tillie" were graduated from various colleges of their own choosing. Each of the boys returned and entered the family cattle and shipping business. After the close of the Spanish-American War in 1900 the two eldest sons, Fred and H. T., then aged 22 and 21, respectively, were sent to Havana, adequately financed, to open an office. There they chartered the parent company, Lykes Bros., Inc. Both survived yellow fever under the care of the famous Cuban, Dr. Carlos Finlay. That same year, Walter Reed proved Finlay's 19-year-old theory that the Aedes mosquito was the vector of yellow fever.

The older sons were soon joined by brothers James and Lipscomb. They bought and consolidated Cuban ranches, built Cuba's first meat packing plant, chartered ships and imported a steady stream of cattle from Florida, Texas, Central and South America.

In early 1906 the sons were notified that Dr. Lyke's health was failing rapidly. They were called home after his death, of unknown cause, at Ballast Point on May 14, 1906. The Tampa Times of May 16, 1906 records that the family, accompanied by "a large concourse of friends," traveled to Spring Hill by special train for the funeral. Almeria McKay Lykes was to survive her husband for 20 years, providing wise and gentle guidance for her family.

The firm of Lykes Bros. was incorporated in Florida in 1910, with the seven brothers and F. A. Morris, who had been with them from the start, as owners. The third brother, James, who

had opened an office in Galveston in 1903, was joined by the youngest brother Joseph. Brothers Howell, Thompson and John managed the Florida interests. More ships were bought or chartered, mostly by James and Joe in Texas, for shipment of cattle and general cargo.

Though quite dissimilar in personality, the brothers (Fig. 5) were bound together by genuine affection, mutual toleration and intense family loyalty. A friend or enemy of one brother held the same role with the others. When the entire family convened in Tampa each February, the brothers invariably met each other with an embrace, the traditional Spanish "abrazo."

Gradually the shipping activity overshadowed that of cattle. World War I caused great expansion in the steamship line. In 1922, Lykes Bros. Steamship Co., with James as president, was created and set apart from the other interests. Smaller steamship companies were purchased and worldwide service established. All ships of the Lykes line were named for members of the family or of the company (Fig. 6). Far greater growth occurred during and after World War II, even though 21 Lykes ships were sunk. One of the great mysteries of the War was the disappearance of the S. S. Tillie Lykes in the West Indies, without a message or trace.[15]

Today, with 54 ships, Lykes Bros. Steamship Co. is the largest American-flag shipping line. Lykes Bros., Inc. is the biggest producer of cattle and is the largest meat packer in Florida. It is also a volume producer of cattle in Texas. Recently the company has become one of Florida's major growers and processors of citrus. Other interests include banking, insurance and real estate.

These various and widespread organizations are still closely held by the equally varied members of the Lykes family, now 84 in number. The sons, grandsons, nephews and sons-in-law who guide the family businesses are as dissimilar in inclination, temperament and physical appearance as were the original seven brothers. Yet few have ever chosen to leave. Fortune Magazine[16] aptly describes the Lykes as "an engaging lot. They have mutual respect and individual independence. They seem to have an hon-



Fig. 5. — A rare portrait of the seven Lykes brothers made in 1940. Standing (from left) are James McKay, John Wall, Frederick Eugene and Lipscomb Goodwin (Dick). Seated are Howell Tyson Jr., Thompson Mayo and Joseph Taliaferro. Dick's picture was skillfully added from another portrait by photographer Carl Blakeslee. The last surviving brother, Joseph, died in 1967.



Fig. 6. — The present S.S. Doctor Lykes, a C-3 cargo-passenger liner, could easily carry the original schooner Dr. Lykes on her foredeck.

est liking for each other." With rare accomplishment, they have indeed been able to "stick together," the one great desire of Dr. Lykes—founder of their empire.

Grateful acknowledgment for aid in the preparation of this manuscript is made to Mrs. Genevieve Parkhill Lykes, Mrs. Louise Lykes Ferguson, Mr. Charles Parkhill Lykes and Tampa historian Mr. Theodore Lesley.

References

1. Lykes, McKay and Allied Families, The American Historical Company, 1953, pp. 15-23.
2. Lykes, F. L. The Lykes Family in Florida, Presented to Florida Historical Society, March 30, 1951.
3. Additional Lykes Data, American Historical Company, 1953, unpublished.
4. Tampa Times obituary, May 14, 1906.
5. Ingram, J. M.: John Perry Wall—A Man for All Seasons J. Florida M. A. 53:709-717 (August) 1966.
6. McKay, D. B.: Pioneer Florida, The Southern Publishing Company, 1959, Vol. 1, p. 47.
7. Ibid., Vol. II, p. 393.
8. Lykes, F. E.: Lykes Brothers, Inc., 1944, unpublished.
9. McKay, D. B.: Pioneer Florida, Vol. I, p. 156.
10. Lesley, Captain John T.: Pocket Diary.
11. McKay, Captain James Jr.: History of Tampa, Tampa Times, 1928.
12. Grismer, K. H.: Book of Tampa, 1951, p. 306.
13. McKay, D. B.: Pioneer Florida, Vol. II, p. 385.
14. Ibid., Vol. II, p. 325.
15. Lykes Fleet Flashes, October 1950, p. 5.
16. Lincoln, Freeman: Fortune Magazine, February 1954, pp. 108-114, 202-212 (by permission).

▶ Dr. Ingram, One Davis Boulevard, Tampa 33606.

Old Doc Anna

As told by Dr. Anna Darrow

We are indebted to Miss Dorothy Darrow, daughter of Dr. Anna Darrow, for permission to reprint these excerpts from a reminiscence left by Dr. Darrow, and for most of the illustrations accompanying this article. We are also indebted to Tierney and Killingsworth, Inc. of Miami for the photograph of the prizewinning painting (Fig. 2)—Medical History Ed.

She was a handsome, even tempered woman who wasn't afraid of the devil himself (Fig. 1). Carrying a large black bag of medicines and instruments she traveled alone four and five days at a time to visit sick folk and deliver babies. She would answer a call day or night, rain or shine, whenever she was needed. Where there were suitable roads, she drove a Model T Ford with head lamps that ran off the magneto. If she drove fast the lights faded, so at night she had to travel in low gear to see where she was going. When the roads were too bad for the Ford she either drove a four-wheeled buggy pulled by a crippled horse or saddled the horse and rode him. The gait of the horse was so peculiar that the country folk knew immediately when "Doc Anner" was in the neighborhood by the sound of the horse's hoofs. She never carried a gun and she always carried $100 in change with her. A favorite trick of some of the country folk was to keep a $50 bill and offer this to "Doc Anner' to pay her fee; if she couldn't change the bill, they considered the debt paid and never again offered to pay. Although it was generally known that she carried this amount of money on her person and did not carry a gun, she was never attacked or even threatened. Indeed, such desperadoes as the Ashleys, the Mobleys, the Rice brothers and the Upthegroves, who left a trail of blood in the south Florida frontier, respected her and at times entrusted their lives to her care. On one occasion the Ashleys took her blindfolded to their hideout somewhere near Stuart to care for one of their family and returned her blindfolded to Stuart so that she would not know where she had been.

She was keenly alert to the beauty of the Florida sunset, the waving sawgrass, the colorful birds and the many flowers around her. She was particularly clever in painting flowers with water colors and beautiful landscapes in oils. Hanging in the office of the Broward County Medical Association is an oil by "Doc Anner" which won her a prize of $1,000 in the hobby show at the 1946 annual meeting of the American Medical Association, Atlantic City, N. J. This depicts an incident when she almost stepped on a diamondback rattlesnake as she alighted from her old Model T Ford to deliver a baby in a pioneer's shack (Fig. 2).

But let her tell the story in her own words... "We soon acquired an old gray buggy horse.



Fig. 1. — "Old Doc Anna," 1909

He had met the Florida East Coast trains to pick up tourists and take them to the hotels in West Palm Beach and Palm Beach and accidentally he was hit on the right hindquarter so was a little lame. I do not recall what Dr. C. R. (Dr. Charles Roy Darrow, her husband) paid for him, but a nice buggy with a top arrived and old Jim soon was carrying me miles out in the sticks to see the sick when the Ford could not make it. Sometimes I had to saddle him and ride out into the back country for there were only trails to follow and many of them went through marshy sloughs. The wheels of the Ford car would skid and finally stop and dig deep into the muck. Unless one was really skilled and knew every foot of the road it was almost impossible to negotiate the water, sand and muck.

"I found that I could make most of the roads without stalling by starting to slow down about half a block from the bad spot, slowing down, putting the car in second and then giving her the juice. In all the years that I drove through the country I never was stuck or drowned out. On one occasion though I really was frightened. I was headed for Fort Lauderdale, had been over to Okeechobee to see a critically ill woman who had been a patient of mine.

"I had taken the trail road to Indiantown snaking in between pines and oak trees. Sometimes only inches to spare on either side. Then all of a sudden I was on a thrown up road that was quite hard and smooth. I noticed a nice big house unpainted to the right and about 150 feet from the gate. I was wondering how far this road would take me when the air was rent with a terrific explosion. The car shook and quivered all over and stopped. Instantly I shut off the gas and leaped out half expecting to see flames leaping up from somewhere. No—no fire, not a thing in the road. The engine was not hot. So I carefully climbed in and turned on the gas and cranked up. All seemed serene. Then I put her in low and she ran, then second and again she obeyed, but high, dead stop instantly. Then again I tried and now I figured something was acting as a brake.

"Yes, sure enough, the arm that held up the front fenders was resting on the wheels. Here was another puzzle—why! Then all of a sudden I saw that the front spring had broken in half. I have always been proud of the fact



Fig. 2. — The prizewinning painting.

that my dad was a high class mechanic and inventor and that I had been blessed with a mechanical spot in my brain.

"I went over to the house, found a pile of discarded building material, found a piece of two by four that would fit into the sagging spring, so I got out the jack and the ax and wire, raised up the body of the car, drove the timber in and wired it and then off for home. I saw a garage in West Palm Beach and I stopped and asked if they had a Ford car front spring on hand. Yes they did. I said, 'O.K. boys, fix her up for me.' Well I will never forget the fun and surprise those mechanics had over my ingenuity. They called everyone in to see what this woman doctor did out in the woods to fix up her car.

"Our trip over to Okeechobee was something I shall never forget. I was anxious to see our new home in the Florida wilderness. There was a thrown up road for about 12 miles out of Fort Pierce. Then suddenly we left it and headed right into water hub deep. This trail through the marsh was 11 miles long to what was called Red Bug Island. Here and there were oak trees, palms and scrub palmettos growing on an elevation. It was a refuge for everything, including man, to get out of the water. Then the next 13 miles of road gradually got better, and after fording a creek, the sides of which were lined with beautiful maples (swamp maple) and cypress, dry land with beautiful turpentine pine tree forest presented itself. Then we crossed the Onosohatchee River, also called Taylor Creek, on a handmade bridge of palmetto trees to support the rough timber which was only wide enough for one vehicle at a time. The river here was beautiful and my artistic eye drank in a picture that never let me rest until I put the scene on canvas, and need I say that today it is one of my prize possessions, and it has been exhibited several times at local art shows and has always brought forth kindly praise as a true representation of our unusual tropical Florida landscape.

"Jim Nash, the carpenter and handyman, arrived. Doc Coon, the dentist, rented an upstairs room for his office. A bank was opened and Mr. Gary was cashier. Soon there were lawyers and doctors, drug stores and veterinarians were scattered around the settlement. There was the promise of a thriving town in the offing. The men formed a business men's organization which met once a week at the Woman's Club building. The women got the idea of gathering in a few dollars so once a week they met and cooked a good old fashioned meal and I made coffee by the gallon and served it. An old fashioned formula that I had learned when just a girl back in old Indiana was followed, tablespoon of coffee to the cup of water. Coffee was carefully moistened with egg before cold water was added, then let come to a slow boil for five minutes, let stand another five minutes and here would be a beautiful golden aromatic drink, served with rich sweet cream. Those days we did not hear the comment when asked 'black please'; common sense told us cream helped to counteract the acid in the coffee bean.

"Mr. Raulerson was one of the handy men of the settlement, sort of a jack of all trades and a fine fellow. One night I heard a rap at the kitchen door. Being a light sleeper I hopped out of bed and hurried to the window and called, 'Who is there?' A man's voice answered, 'Doc, my shoat is having convulsions.' Here I was stumped. I did not know what a shoat was but thought it was the name of his child. In old Indiana it was hog, pig and piggie. So I said, 'How old is the child?' 'Oh doc, it's my three weeks old pig that has drank so much cane skimmings he is having convulsions.' Then I ran back to Dr. C. R. and told him Will Raulerson's pig is having convulsions from drinking too much cane skimmings—it was syrup time. Dr. C. R. answered back, 'What does he think I am, a vet?' I realized that our reputation might be at stake so I hurried back and asked him if he could tell me how much the shoat weighed. I figured out quickly that it would come to the 12 pound weight of an infant. When Doc and I graduated in medicine, Dr. Abbott in Chicago, whom I had met personally and whose medical laboratory I had visited, known for the invention of the alkaloids, gave us each a kit of a complete drugstore. This was one of my most cherished possessions, for no matter where I was called I could always find in my handbag an indicated remedy.

"Now here was a challenge to my ingenuity. A 12-pound shoat with convulsions. I hastened to the chart, figured out what was indicated and gave the pellets to Will and told him to give one every two hours with water from a small bottle. If the piggie acted cold to cover it up. The experiment was a success and it was soon noised about that old Doc Anna was a fine doctor, so everything that lived and breathed became a patient.

"Two men were bitten by the black widow spider. They rushed to me all in a cold sweat and nausea. Again Lloyd's preparations saved the day. Two others bitten by tarantulas and a centipede, no fatalities. By this time I was known far and wide as "Old Doc Anna." The Indians came to us with many types of illness. I had doctored a little four year old Indian boy brought in by Billie Bowlegs. 'Pickinniny die sun up,' the chief told me. I looked at him in astonishment and wondered if they were performing a rite. It did not take me long to diagnose acute pericarditis—and 'pickinniny no die if you do as I say.'

"I persuaded them to camp near Judge Hancock's home and bring the boy in every day. It not only surprised the Indians but I must confess I was unduly pleased. Then I carefully instructed them in his bringing up. No punishments or undue excitement. I had heard one of the ways they punished unruly children was to tie them out in the water up to their neck. This shock treatment would probably prove fatal.

"I let all the Indians listen to my heart through the stethoscope. The boy's heart had a marked friction rub. Whether they got this, I do not know except that from that time on I was 'Squaw Doctor' to the Indians. They hung beads about my neck and said a ritual. Five years later they brought this boy in to see me and I was pleased to note his heart was in good condition and he seemed to be a normal happy Indian boy.

"Going back to our days in Okeechobee, I recall that there were four M.D.'s who came and located there and set up business. One in particular opened up a drugstore just around the corner from us. One of the drawing cards of his establishment was a cold drink stand, which we did not have. But this nearly cost him his life. Cattle roamed at will and one of their stunts was to turn over the garbage cans in the



Fig. 3. — Left to right: Miss Dorothy Darrow, Dr. Charles Roy Darrow, "Tin Lizzie," Dr. Anna Darrow, Otto Scharfschwerdt, Grandmother Lindstedt and Grandmother Darrow.

alleyway. The chemical called High Life,* smelling like a batch of rotten eggs, thrown on the cattle or dogs would run them off. The doctor, who owned the drugstore liked his liquor too. One of his clerks had filled a tumbler with High Life to throw on a cow and put the glass down on the counter in the rear of the drugstore. The doctor also had poured out a glass of water to drink after his draft of liquor with one of his customers. He picked up the glass of High Life instead of water and downed it.

"In less time than it takes me to write it he collapsed. Dr. C. R. and I were closing up the drugstore to leave for home. Suddenly we heard a terrific hammering and yelling at the front door so Dr. C. R. hastened to open up and in stumbled two men carrying the doctor unconscious. They said, 'Doc, he took High Life by mistake as a chaser for the liquor.' I can't ever remember putting up a bigger fight to save a life. Dr. C. R. and I worked all night, pumped out the stomach and hurriedly made a starch solution and added bismuth subnitrate to coat the burned mucosa of his stomach. I had heard it noised about that he had made his brags that he was going to run the 'petticoat doctor' out of town. He got tired of having 'Dr. Anner' quoted to him as an authority on how to treat sick folks. By this time the folks around the lake area found that I had learned their ways, their language, their superstitions and their way of life. I tried not to act surprised when I visited a confinement case and the patient was complaining of severe afterpains and the husband came in and found that the scissors had not been put under the mattress to cut the pains, or if a hoot owl called suddenly, 'Who, who cooks for you all,' to quickly turn your pocket inside out will break their bad luck.

"Going back to the High Life case, Dr. C. R. and I did a lot of worrying for here was a very sick man. We wired for Dr. McEwen of Orlando to come quick. He went over the case with us and to his knowledge he had never heard of, or seen a case of High Life poisoning and told us we had done everything humanly possible to save the doctor's life and could suggest nothing but to wait and see and meet symptoms as they arrived.

"That reminds me of a comical thing that happened to Dr. Alsobrook and me. Can you picture a fine looking middle-aged woman with black hair, flashing black eyes and a faultless complexion, straight as a ramrod, the mother of five grown up children and about to be in on seeing a child born for the first time. Her daughter had come in from the lake and was suddenly in the throes of labor. I was sent for in a hurry. There was no extra bedroom or bed. My patient was lying on an old Army cot in the middle of a room alongside a rough homemade table with a kerosene lamp on it. Of course, there was nothing prepared for this emergency so I had to think quickly to calm the situation. I told her to please heat water with which to boil up my instruments. Anything to keep her busy and calm her nerves.

"In the process of delivery the patient had one of those resting spells come on and the mother got very excited thinking that something had gone wrong. In order to be doing something myself I turned the patient over on her side and massaged her back and told her she was doing fine. All of a sudden the ordeal was over so I delivered, on her side, a fine six pound girl. Grandma was delighted.

"A short time after that I got a call one night for a confinement just up the road from Mrs. K. I had not been engaged and I had just returned from one of my trips over on the lake. Dr. C. R. said, 'Don't go—tell them to call someone else.' About noon Dr. C. R. called me and said that Dr. Alsobrook wanted me to help him on a confinement case, said he did not like to put on forceps. I got dressed and hurried down to our drugstore where Dr. Alsobrook was waiting for me. We hurried through the woods and prairie and as we sped on I noticed we passed Mrs. K.'s place, then on into a hammock where there was another old tin shack. Just as we stopped our cars and got out with our instruments, out came Mrs. K. dressed in a dark house dress with a white apron frantically waving it up and down screaming at the top of her voice, 'Oh my God I have done it—oh my God I have done it. I turned her over on her side just like Dr. Anna did my daughter and here comes the baby! I just come over to see and get some drinking water—oh my God I have done it.' We stopped in to take a look at the situation. Here was a bouncing 12 pound baby and a badly lacerated mother. Dr. Alsobrook took one look and said, 'Doc sew her up!' and hopped into his tin lizzie and sped for home.

*Carbon disulfide

"I cajoled Mrs. K. into calming herself, praising her ability to meet an emergency, but cautioned her that if she persisted in copying me she would have to get a license.

"I never knew in what direction or how far my next call would be. Could I make it by horse and buggy or Ford? Usually those who sent their messengers for me would be specific in directions. Many lived on houseboats and fished for a living. The Booth Fisheries found a market for the Okeechobee cat fish. One day a woman was bleeding to death and I did a curettage on board this moving houseboat. A little 9-year-old boy directed me to the right boat. She was unconscious, but I got out all my paraphernalia, instruments and medicines and did my job so well that when I called on her three days afterward she said, 'I am delighted to meet you—I wondered what you would look like. Nine years ago I had the same thing happen to me and I was in a hospital with all kinds of doctors and nurses and it cost me $500. Lady you amaze me and I thank you for saving my life.'

"One night a man called out at our front gate on Parrot Avenue, 'Old Doctor Anner.' I hopped out of bed and went to the door and asked, 'Who is calling?' 'You are wanted on the ridge, a woman is very sick. The boat is waiting for you at the dock.' I asked, 'What is the trouble?' 'Don't know,' he replied. So I dressed, started up the car and made for the dock.

"I handed the two men the emergency outfit, climbed into the boat and we were putt-putting, headed for the lake. The night was very dark. I marvelled at their steering skill, when all of a sudden we stopped on the middle of a sand bar unable to push off. One fellow jumped overboard, handing me his oar. With all pushing we were soon off again up the river to the lake. Entering the lake they turned and headed toward the ridge at the mouth of the Kissimmee River. A gray mist hid the shoreline and the only sound to break the stillness was the purr of the little engine and the call of an occasional night bird. Hours were slipping away and I was wondering how much further we must go, so I asked and one fellow answered, 'We kaint see the light yit.' The other fellow answered, 'I hope it did not go out,' so I resigned myself to hoping we were not lost for after all Lake Okeechobee is a big expanse of water. I also wondered about the patient, for they only called me when it was urgent. Just as we were all getting anxious the faint glow of a kerosene lantern, hung on the arm of a piling, flickered into view. Tying up to this rickety dock about half a block from the ridge, I took off my shoes and stockings, waded ashore through weeds, lily pads and water up to my knees. The men carried my medical kit. It was a rugged half mile following the men with the lantern to the corrugated iron cabin. Depositing my kit and pointing, 'In there,' they disappeared in the darkness.

"Rapping on the door I got no reply so I pushed it open. There under a mosquito net canopy, on a spring and mattress supported on four grocery boxes, lay a comely woman, semi-conscious. I finally aroused her and said, 'This is Doctor Anna, what can I do for you?' She replied, 'So glad you are here, I am mighty sick. Had a chill yesterday and now I have labor pains.' No more questions were answered for she lapsed off into a stupor again. Temperature registered 106, pulse 120 per minute. Patient drenched in sweat. I made the clinical diagnosis of acute malaria so gave seven and one half grain ampule of quinine dihydrochloride deep in the thigh. It was now early morning and labor was progressing rapidly and became quite rugged, so Abbotts H.M.C. was given hypodermically. About 4:30 a.m. a perfect five pound girl arrived, uttered a few feeble cries and passed out in my arms. I hurriedly placed the dead infant on a trunk in the corner and turned my attention to the mother who was making a desperate effort to live.

"About eight o'clock she rallied enough to ask me if she has given birth to a baby. I replied, 'Yes dear, you have, but sorry your little girl was too sick to live.' She closed her eyes, face as white as alabaster, a wealth of dark braided hair wrapped about her head like a halo reminded me of a real madonna. All through the ordeal there was no loud groaning or piercing cries, just a calmness that so often precedes death. Here was a challenge I had to meet.

"Finally, I was able to leave the bedside a moment and I looked over to the trunk where the dead infant lay. Much to my surprise and horror the wood rats were scampering all over the baby and gnawing at it. They were coming in through a crack in the corner. I finally found an old towel, wrapped up the baby and placed it under the screen canopy at its mother's

feet. About nine o'clock I heard a familiar call, 'Dr. Anner', a man's voice outside said, 'if you will go up the trail a quarter of a mile Mrs. C. will give you breakfast.' By this time I needed sustenance so I stepped out and here again were two strange men to direct me. They pointed to another tin cabin and disappeared. This middle-aged woman wasted no time on words, 'Howdy, how is Mrs. S.?' I replied, 'Better thank you, but the baby girl died.' She said, 'Sit,' and placed before me a plate of hot biscuit, syrup and cup of coffee and disappeared. I hurried back to my patient, took temperature and pulse, which were almost normal, so I was certain my diagnosis was correct. After the cleanup I gave another ampule of quinine and doled out medicines out of my miniature drug store with written instructions to meet any emergency or for a normal recovery; also a thermometer and instructions to call me again if necessary.

"Suddenly I became conscious of my legs burning and a crawling sensation all over. I had been too intent on saving my patient's life to feel discomfort. Recalling wading through the weeds I thought I would look and see how many scratches I had sustained. Now I was in for a surprise. Fleas were hopping right and left. The gray, slow moving hog lice were crawling through my clothing and a red bug had fastened here and there. I hastily undressed and disposed of my crawlers. It was now past noon and I was wondering how I was to get back home when the familiar 'Dr. Anner' sounded outside the cabin and another stranger handed me a little wooden coffin for the baby. 'Dr. Anner, if you are ready to leave follow me to the dock and we will take you home.' He grabbed my emergency kit; it kept me stepping to keep up with him but by this time it was daylight well into the afternoon.

"I was looking for a dry spot in the boat to sit down and put my shoes and stockings on, when I noticed a stiff breeze had sprung up. A big wave slapped the boat sidewise and I had to grab the housing to stay on board. Wave after wave broke, some going over my head and drenching me to the skin. Finally, we outrode the squall and turned into the mouth of

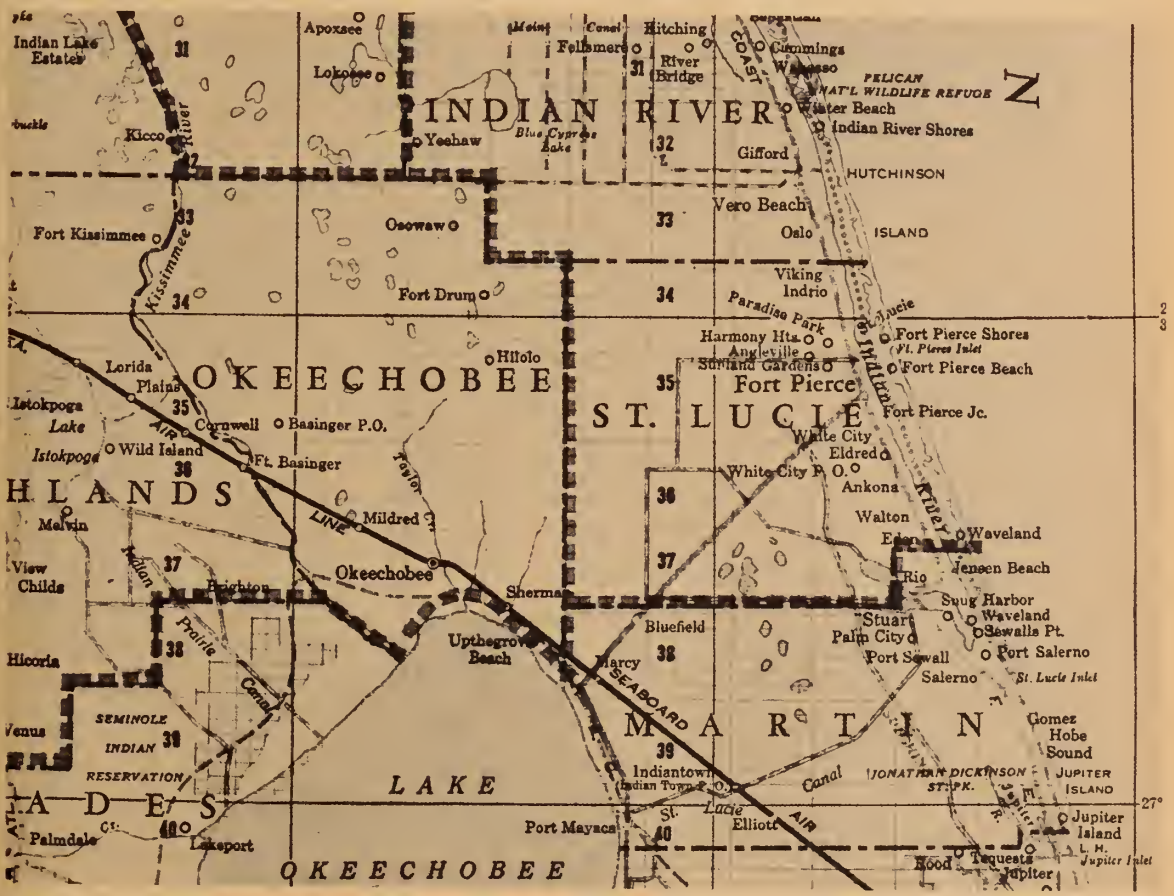


Fig. 4. — ". . . she made calls from Ft. Drum to Bassinger and even out to Indiantown" (Reproduced by permission of the State of Florida, Department of Agriculture).

Taylor Creek under the bridge. Going up the river the hot sun dried our clothing. The Ford standing by the river bank was a welcome sight.

"Days went by and no word from the patient on the ridge. About three weeks later, a fine looking husky fellow came into the drug-store and inquired for 'Doc Anner.' I stepped out from behind the prescription counter and said, 'Yes, who wants me?' 'I am Mrs. S.'s husband, you took care of her when I was out on the lake fishing. What do I owe you? Here is your thermometer.' I told him what his bill was and added, 'But please tell me how is your wife getting along?' He answered, 'Fine, thank you,' placed the money on the counter and left without another word."

Anna Albertina (Lindstedt) Darrow was born on a farm in Jasper County, Ind. in 1876. She attended the Kirksville School of Osteopathy in Kirksville, Mo., then studied medicine at the Jenner Medical College and the Chicago College of Medicine and Surgery (a forerunner of the Loyola University Medical School), graduating with honors in 1909. In 1912 she and her husband, Dr. Charles Roy Darrow, who was a surgeon, moved to Okeechobee where he was to serve as surgeon for the Florida East Coast Railway. Okeechobee, or Okeechobee City as it was sometimes called, was known as Tantie in 1912. It consisted of a few frame houses and buildings clustered around sandy trails leading to Taylor Creek. Unpromising as it looked in 1912, Mr. Ingram, Henry M. Flagler's promoter, assured the Doctors Darrow that as soon as the railroad reached there it would blossom out into another Palm Beach or Miami.

While her husband stayed in town, did the office practice and ran the drug store, Dr. Anna made the house calls back in the woods from Fort Drum to Bassinger and even out to Indiantown (Fig. 4).

The Florida East Coast Railway reached Okeechobee in 1915 but during the ensuing years the predicted real estate boom did not occur.

Discouraged by the lack of growth of Okeechobee, in 1922 the Doctors Darrow moved to Stuart and in 1924 to Ft. Lauderdale. Dr. C. R. Darrow died in 1926 but Dr. Anna Darrow continued to practice in Ft. Lauderdale until 1949. She was an active member of the Broward County Medical Association and served as its secretary more than once. In 1949 she retired to her daughter's home in Coral Gables where she suffered a cerebrovascular accident in 1957 and a second and fatal one in 1959. She is buried in Ft. Lauderdale.

A Short History of the University of Florida College of Medicine to 1960

Mark V. Barrow, M.D.

The University of Florida's College of Medicine continues to grow. Begun in the early 1950's, completed in 1956 and graduating its first medical class in 1960, Florida's state-supported medical school is now entering a rapid growth phase, difficult to follow and document with the rapid changes and advances. For this reason, and since there seems to be an ever increasing loss of many of the men and women responsible for this medical center, it seems appropriate to pause and review the brief but very busy history of this medical school in its initial phases of development.

The Early Years: to 1949

Florida's educational history dates to 1845 when this new state established two seminaries which eventually found their permanent homes in Gainesville and Tallahassee. The West Florida Seminary (later to be Florida State University) in Tallahassee was approached regarding establishing a medical college as early as 1883. According to Merritt[1] a Reverend John Kost and a "board of regents" founded within the seminary a Literary College and Medical College. The Florida Medical Association, organized some nine years earlier, did not approve the seminary faculty, which mainly consisted of Tallahassee practicing physicians, and this initial attempt was thwarted early and was dead by 1886.

Concern about Florida's health needs thereafter lay quiescent until World War II when Dr. John J. Tigert, then president of the University of Florida, made a public statement recognizing the need and indicating that if Florida was to have a medical school, the logical location for such an institution would be Gainesville because of its central location and the benefits to be derived from an affiliation with the university. Other Floridians shared this desire with the result that the 1943 state legislature recommended establishment of Schools of Medicine, Dentistry and Pharmacy in Florida without stipulating any funds or specific location.[10] No support was rallied, however, the recommendation was not implemented and later this bill was abolished because no further interest was engendered. The need of physicians was clearly shown, however, since in the mid-1940's a ratio of one active physician per 911 persons existed in Florida while the national average ratio was one doctor per 710 persons. Concern over this state of affairs and Florida's education system in general led to Governor Millard Caldwell's executive order for the formation of the Florida Citizen's Committee on Education in 1945. This committee was composed of 16 citizens, including teachers, businessmen, lawyers and ministers of Florida. Their purpose was to conduct a survey of all types of educational facilities in Florida. A concurrent resolution by the Florida Senate encouraged the activation of this committee.[11]

The committee's report, entitled "Education and the Future of Florida" was issued in March 1947. Under the heading of "Education in Medicine, Dentistry, Pharmacy and Nursing," Chapter 23 presented a summary of the status of the medical profession and related services as it existed in 1945 in Florida. The following recommendations were made: that ample support be given to public schools and the universities before undertaking a costly enterprise such as medical education; that hospital construction and maintenance demands for the state be appraised further before launching the medical education program, and that when the state was ready to build a medical school it should be located at the University of Florida.

In 1947, Dr. J. Hillis Miller became the fourth president of the university. In his inaugural address he projected a vision of a large health center complex.[12] Apparently the Citizens' Com-

From the Department of Medicine, College of Medicine, University of Florida, Gainesville.
Supported in part by National Heart Institute Cardiovascular Training Grant 5T1 HE 5493.

mittee recommendations, Dr. Miller's appointment and the increasing ratio of one doctor to 1,100 citizens stimulated the legislature's interest, for during that year House Resolution 43 and Senate Resolution 16[13] authorized a survey of health services in the state to study the needs, location and cost of a medical school in Florida. Responsibility for this study was delegated to the State Board of Education and the State Board of Control. These two groups and a Medical Survey Committee composed of the secretary of state, the president of Florida State University, the chairman of the Board of Control and president Miller, after consulting the Association of American Medical Colleges and the American Medical Association, selected Dr. Vernon W. Lippard, then dean of the school of medicine at Louisiana State University, to conduct the survey. His appointment was announced in November 1948, and the results of the study were submitted to the Medical Survey Committee Feb. 1, 1949, after review by an advisory committee consisting of several prominent medical educators.

The principal recommendations of the "Lippard Report,"[2] as it became known, were as follows:[1] A school of medicine should be built in Florida when funds to build an institution were assured; (2) A school of nursing should be built simultaneously with a curriculum at the college level in order to prepare leaders in the field of nursing education and administration for the state; (3) A university hospital should be established for instruction and research in clinical medicine so as to provide the highest type of medical service which could be available to citizens throughout the state; (4) A school of dentistry should be considered in the initial plans but not opened until the previously mentioned schools were operating for a few years; (5) All these facilities should be integrated structurally and functionally as a medical center with a focal point for development of the educational programs in medicine and related fields; (6) The center should be under administrative control of the University of Florida and should be located on the campus of the University of Florida, and (7) The overall program should be developed over a ten-year period beginning with initial appropriation of approximately $65 million for employment of architects and construction of a medical sciences building, with additional funds for completion of the projects to be appropriated in the following sessions of the legislature. It should be noted that these recommendations for facilities and sums of money were heretofore unheard of in Florida politics or educational schemes.

As to the adequacy of the clinical material, it was predicted that hospital patients coming from throughout the state would be sufficient. A final comment on medical education mentioned "a tendency to rate excellence of instruction according to the number of patients a student sees, or the number of physicians on the faculty, rather than how carefully the patients are studied or how much time and interest members of the faculty devote to teaching and research; large populations and a large number of part-time instructors are not essential to developing a good educational program."

This report served to unite sentiment regarding establishment of a health center. Furthermore, it evoked interest in the future of medical education and the service of the proposed medical college to Florida.

Therefore, with the need clearly outlined, the state seemed set for establishment of a state medical school, and indeed, the state legislature was prepared to establish one during the 1949 session.

The Planning Years: 1949 to 1954

In April 1949, the state legislature passed Senate Bill #329[14] which authorized the creation and establishment of medical and nursing schools at the University of Florida; however, no monies were appropriated for this. A "Faculty Advisory Committee" under the watchful eyes of president Miller was asked to outline a research study which would chart a course of action for the functioning of a college of medicine and nursing within the framework of the university. One of the members, Dr. Turner Z. Cason, a leading Jacksonville physician and long-standing advocate of a state-supported medical school, had been holding short courses in medicine sponsored by the university's General Education Division and this had engendered interest in a medical school at the University of Florida. The Faculty Advisory Committee was a nebulous group; they had no formal meetings, but individuals and subgroups of the committee recommended that a research study explore administrative aspects, sociological and economic factors and integration of existing university programs in teaching and research with those of proposed schools. They recommended also that a director be selected. During this time

rivalry existed in Florida's three largest municipalities—Jacksonville, Miami and Tampa—as well as Gainesville, for a state medical school. Dr. Cason's influence was helpful in curbing legislative pressure for the selection of Jacksonville as the site of a medical school. Dr. W. C. Thomas Sr., a practicing Gainesville physician, was also on the Faculty Advisory Committee as well as being president of the Florida Medical Association at that time, and was the principal advisor in selecting the 14 practicing Florida physicians for membership on the important Medical Advisory Committee[15] for the future medical center study of 1952 (later to be explained). He, therefore, also played a key role in keeping the location of the medical school in Gainesville.

On May 12, 1950, president Miller wrote his consulting architect, Jefferson M. Hamilton, that he had been advised of a Florida State Improvement Commission grant of $10,000 "for the purpose of advance planning of a college of medicine and nursing with estimates of $10,160,-000."

Dr. Vernon Lippard again was selected. He was to be assisted by Dr. Basil C. MacLean, director of Strong Memorial Hospital, University of Rochester, who was chosen by Dr. Miller and a member of the Florida State Improvement Commission. They were to act as consultants and to advise as to what direction should be taken in studying and planning for a medical center.

The two consultants, ably assisted by Jefferson Hamilton who acted as a liaison between the consultants and Dr. Miller, held closed sessions for two days and actually produced a report on total facilities needed, including a comprehensive outline of the nature of services to be performed, the type of patient to be reached in the state, and the size of classes for a college of medicine and nursing. The "Lippard-MacLean Report" also recommended a construction program providing for an annual medical class of 75, a 750-bed hospital, a medical student dormitory and a nursing student dormitory. Using funds remaining from the grant, Mr. Hamilton also visited several leading medical colleges at the request of administration. During one of these visits Dr. George T. Harrell, then research professor of medicine at Bowman Gray School of Medicine in North Carolina and subsequently the first dean of the University of Florida College of Medicine, was contacted. This occurred somewhat by accident and was the result of Mr. Hamilton's inquiring of



Dr. Harrell

Duke University whether Bowman Gray School of Medicine might have anyone interested in physical planning and medical education. This ultimately led his being referred to Dr. Harrell.

In 1951, the legislature, toward the end of the session, appropriated $225,000 for subsidizing the first accredited medical school in Florida ($3,000 per student).[16] The University of Miami soon established a private medical school, but only received the $3,000 per student subsidy after a court fight with alumni from the University of Florida who were hoping to delay the Miami school until the state medical school was finished. Almost as a conciliation to Gainesville's District #32 Senator William A. Shands and Alachua County Representatives Ralph Turlington and W. E. Whitlock, an added section to the subsidizing statute appropriated $100,000 to the Board of Control for the purpose of drafting plans for erecting a state medical school at the University of Florida. A further impetus for actual establishment was announced on April 1, 1952, when Dr. Miller, in a speech to the Duval County Medical Society, announced the award of a $96,500 Commonwealth Fund grant for implementing a medical center study. An office for this purpose was set up in the Administration Building of the University of Florida on June 1, 1952, with Dr. J. M. Maclachlan, given a year's leave of absence as head of the de-

partment of Sociology and Anthropology, acting as chief of staff.

On July 1, 1952, Dr. Russell S. Poor, former dean of the graduate school and director of research at Alabama Polytechnic Institute and director of university relations at Oak Ridge Institute of Nuclear Studies, who was on leave of absence and setting up grant procedures in Washington, was appointed as director of the medical center study (Fig. 1). He first had been recommended to Dr. Miller in July 1951 by Dr. J. Ivey, director of the Southern Regional Education Board, with whom he had served on several educational committees. After acquiring a research staff of five, two secretaries and a clerk, the study was launched. One of the first steps taken was establishment of an executive committee composed of educators and physicians and the organization of the previously mentioned Medical Advisory Committee of 15 Florida practitioners.

The executive committee had several formal meetings during the latter half of 1952, and with director Poor, consulting architect Hamilton, and often president Miller present, plans were shaped to meet the philosophy of the future health center. Dr. George T. Harrell, who was made one of the members of the executive committee, was asked by the committee to accompany Mr. Hamilton to study existing medical schools. In all, they visited more than 20 medical schools, and in their reports were able to cover not only the different philosophies of teaching medicine, but the manner in which these were aided or hindered by the respective physical plants.

The purpose of the medical center study was to determine how the center could serve the health needs of Florida.

The basic philosophy of the proposed center could be summarized at that time by the statement that those who train together will work better together after completing training and beginning practice in Florida towns.

The undertaking previously outlined was begun by the medical center study staff under the guidance of Dr. Russell S. Poor, and was ultimately published in 1953 in five volumes, known as the Medical Center study series.[3] Volume I was a summary of the entire study while Florida's physicians in midcentury were discussed in Volume II. Volume III described the health needs of the people of Florida; Volume IV discussed Florida's hospitals and nurses, and Volume V provided a resumé of university programs related to medical education, research and service. Each section of the last volume represented the collective thinking of the staff in the units concerned.

Out of this study came the following proposals: Florida has an immediate need for a medical education program; a health center to begin meeting these needs should be established at the University of Florida, since some 66% of the state's population was within a 150-mile radius of Gainesville; facilities of the center could be easily integrated into the University of Florida, thereby saving expensive and unnecessary duplication of facilities and services; $5 million should be appropriated for construction of a medical sciences building and $7 million should be appropriated in the next session of the legislature for construction of a teaching hospital and Florida should continue to use the regional plan after the center is constructed since the growing needs may not be completely met by the proposed center.

Prior to publication, copies of the study were submitted to president Miller on March 10, 1953 and passed on to the 1953 legislature, while a summary was given to the Florida Cabinet. The legislature had been well prepared for favorable consideration of appropriations for a health center at this time.

It was, therefore, no surprise when in April 1953, the legislature appropriated $5 million for the building of a medical sciences building to house the Colleges of Medicine and Nursing on the campus of the University of Florida, with the recommendation that the already functioning College of Pharmacy and Cancer Research Laboratory be integrated into this unit later. This was an unprecedented amount of money to be appropriated by the legislature and was one of the largest single sums ever allotted up to the present. Guy C. Fulton, architect of the Board of Control, was assigned to the project.

As the philosophy and program for the new health center took form under the guidance of the executive committee during 1953, it became evident that Dr. Russell S. Poor, with his ability to organize and pick key administrative personnel, would be a logical choice for provost of the health center. This was to be a position extending the arm of the president to groups of colleges which would need more attention than the president himself could give—in a sense, a vice president. It also became obvious that Dr. George



Dr. Poor

T. Harrell (Fig. 2) would be the logical choice for the new dean of the college of medicine. His broad knowledge of medical education, his grasp of the organization and administration necessary for a new medical school and particularly his understanding of physical planning for so complex an institution were believed to make invaluable his guidance in translating expressed ideas into reality. Dr. Poor was appointed provost in August 1953 and Dr. Harrell was selected as dean of the college of medicine in October 1953, though he could not leave his post at Bowman Gray until Jan. 1, 1954.

All plans were moving forward when tragedy struck on Nov. 14, 1953 with president J. Hillis Miller's untimely death secondary to congestive heart failure and aortic insufficiency, thereby creating an administrative gap in day-to-day planning. Although his excellent administrative ability and creative vision were missed, Dr. Poor and Dr. Harrell slowly and carefully proceeded with their plans, the general direction of which had already been set by Dr. Miller assisted by the university's vice president, Dr. John S. Allen, who became acting president.

It had been decided to phase the building of the medical center so that the medical sciences building would be given first priority with an aim of having the buildings ready for occupancy by the fall of 1956. On June 18, 1954 the Board of Control approved the plans for the long range development of the medical sciences building and the teaching hospital. In order to save time, the contract for the foundation of the medical sciences building was let separately, with Rusk Engineering Company of Birmingham as successful bidder at approximately $1.5 million. The site of construction was to be on Florida porous limestone with little stability and it was thought the most feasible foundation would be a six to eight-foot thick, rigid concrete slab, floating mat. Although their work was completed promptly, considerable effort was expended because of the terrain. On July 27, bids were let for the superstructure of the medical sciences building with four companies responding and all bidding very close to $3.5 million. On Aug. 3, 1954 the Ajax Construction Company, Washington, D. C., submitted the low bid of $3,376,000 and construction was to begin shortly thereafter.

The Building Years

By the fall of 1954, construction had not yet begun. The contract with Ajax was found to have a defect in it in that no beginning date was specified. This and other technical disagreements between architect Guy C. Fulton and Ajax Construction Company ultimately led to cancellation of the contract on Dec. 9, 1954, but only after considerable pressure from Florida's attorney general. New bids were opened on Jan. 3, 1955, and Arnold Construction Company of West Palm Beach was awarded the contract for the medical sciences building when they submitted a low bid of $3,549,000. At about this same time the name was changed by the Board of Control from University of Florida Health Center to the J. Hillis Miller Health Center in memory of the late president.

As dean, Dr. Harrell also had several unique ideas which he wished to try to incorporate into the health center program.[6-9] These included: (1) Using a flexible training plan for M.D. and Ph.D. candidates; (2) Utilizing Florida's physicians in an active preceptorship program for training fourth year medical students; (3) Establishing small, apartment-like family rooms on each hospital floor for family and patient education in medical care; (4) Individual study cubicles for each medical student which would be his own "thinking desk," book storehouse, or "office," and (5) An ambulant wing with a motel-like atmosphere which would house patients not needing constant attention. While some of

the ideas were never fully realized for a variety of reasons, the study cubicles and ambulant wing ultimately were quickly accepted and utilized.

Dr. Harrell and Dr. Poor also had definite ideas about the size of the medical classes. The physical plant, laboratories and lecture rooms were flexibly designed for instructional groups ranging in size from four, since many experiments in physiology, pharmacology and anatomy are done in groups of this size, to a maximum of 64 students. They believed that relatively small medical classes would be more likely to insure high quality training and the program would be easier to evaluate, easier to modify when necessary and more economical than larger ones. Furthermore, they believed that the state would be better off with a smaller number of well-trained physicians.

Construction of the medical sciences building began at last. Arnold Construction Company dedicated themselves to catching up with the time lost earlier and did so with amazing speed.

The legislature approved $8.6 million for construction of the teaching hospital[17] on April 13, 1955, thus ensuring the establishment of the second phase of the medical center.

While construction of the medical sciences building progressed—it appeared the building would be ready for occupancy in the fall of 1956—the prospective faculty for teaching of the basic sciences was being interviewed. Acquiring a faculty at this stage was, of course, a problem. The story is told that one interviewee commented, on seeing the water-filled foundation surrounded by high weeds, "There will never be a medical school here," and left (he later became a faculty member, however). Nevertheless, positions were filled over a year's period, probably in part because of several early key appointments of high quality, as well as Dr. Harrell's persuasiveness.

Following key appointments in the basic sciences and in the College of Nursing, clinical department heads were selected and completed by September 1958. Young academicians were among the majority chosen, ranging in age from 33 to 40, and most of these men were not particularly well known, though they were believed to have substantial potential.

The medical sciences building was completed in the fall of 1956, barely in time for the first medical class of 48 students. The cost of the 238,000-square-foot building was $5.4 million.

As previously mentioned, major teaching laboratories were designed to be used for instruction of an entire class or to be quickly adapted to the needs of smaller groups. Each student was assigned a study cubicle for the first two years. The medical sciences building also housed the health center library which had been remarkably well stocked during the previous few years by librarian Fred Bryant.

The teaching hospital ground-breaking ceremony was in April 1956, but by that fall funds for construction were nearly depleted. During an extraordinary session in 1956, after encouragement by Senator W. A. Shands and Representative Ralph Turlington, the Florida legislature appropriated an additional $1,225,000 for completion of the teaching hospital. The following year the legislature authorized the building of a dental school as part of the health center, though money was not appropriated.[18]

In October 1958, the teaching hospital was completed and opened at a cost of $9.8 million with a square footage of 375,000. The first patient was an 8-year-old girl from a small North Florida town. Formal dedication was not until a year later on Nov. 20 and 21, 1959. The teaching hospital, clinics and ambulant wing consisted of seven floors and a connecting section between the hospital and medical sciences building like the middle bar of an "H." The two buildings were related floor by floor, with similar functions in the clinical sciences and hospital being placed on the same floor. The ambulant care facility consisted of 26 rooms with two beds each; it was designed to reproduce the environment of the home and was in a separate wing of the hospital, closely related to the outpatient clinics. The clinic was designed to be used as a general clinic by all departments as well as a series of specialty clinics. The waiting room consisted of a large area spread around a patio, giving a garden effect. Available to all medical services were such related specialties as Physical and Occupational Therapy, Prosthetics, Speech Pathology, Clinical Psychology, and Audiometry. Nearly 15,000 square feet of floor space was devoted to these rehabilitation functions. A unit manager system was initiated on the hospital floors, whereby a nonmedically trained person managed the day-to-day administrative duties of each floor, thus freeing the nurse for patient care duties. A sitting room adjacent to the labor room for family use was incorporated in the maternity suite. Thus, with the opening of the teaching hospital, the medical center, as originally conceived, neared completion.

During 1959 several key developments contributed to the health center program. In the spring of 1959, the Florida legislature appropriated $1.4 million[19] along with $640,000 in federal matching funds which was procured from the U. S. Public Health Service for construction of the pharmacy-research wing on the western end of the medical sciences building. This would allow for the College of Pharmacy led by dean Perry Foote, a University of Florida professor of long standing, which had been under administrative control of the office of the provost since 1954, to move from the mid-campus location and be integrated as a functional part of the health center. The ground-breaking for this unit was on Nov. 11, 1959. The wing was completed and occupied by September 1961, with an approximate total square footage of 60,000. Of this footage, 27,000 feet was to be used by the medical school for research purposes.

By 1960 all units were functioning well. In the spring, approval of the curriculum and full accreditation was given to the College of Medicine by the American Medical Association and Association of American Medical Colleges. On June 6, 1960, the College of Medicine graduated its first medical class consisting of 40 students, who dispersed to all corners of the country for internships.

Conclusion

Since 1960, the medical school has entered a rapid growth phase. Some aspects of this development are covered elsewhere[20] and will be summarized for this Journal at some future date.

Several points may be gleaned from this history. First, 17 years transpired from the Florida legislature's action in 1943 until the completion of the College of Medicine and the graduation of its first students. Second, a half-dozen committees, consisting of over 60 members and frequently nonmedical, some of whose members visited numerous medical schools and devoted long sessions to involved planning, accurately summarized the needs of Florida for a new medi-



Fig. 3. — Present University of Florida College of Medicine

cal school. Third, the personal enthusiasm of the early planners and builders of the medical school may well serve as a hallmark in Florida's medical history for decades to come. Finally, the medical school served as a testing ground for several new and unique ideas in medical education, including the study cubicles, ambulant wing and others. Today the cubicles and ambulant wing are being incorporated into new medical schools the world over.

Florida can be proud of its state medical school. Continued support of its endeavors for improved higher medical education and better health care of our citizens is imperative as is its continued dedication to its purpose—excellence in in medical care, excellence in teaching and excellence in medical research.

Acknowledgments

The following persons are gratefully acknowledged for freely giving their time, thought and assistance in the preparation of this manuscript: Miss Edith Pitts; Mrs. J. Hillis Miller; Charles Pruitt; Russell S. Poor, Ph.D.; George T. Harrell, M.D.; Representative Ralph Turlington; Joseph Weil, Ph.D.; W. C. Thomas Jr., M.D.; Arthur Koch, Ph.D.; Guy C. Fulton; John S. Allen, Ph.D.; J. G. Wilson, Ph.D.; Mary Barrow; Dorothy Smith, R.N., and Constance Lagoni, secretary.

The author is especially indebted to W Jape Taylor, M.D., his mentor and friend, who critically reviewed this manuscript on several occasions, and Jefferson M. Hamilton, who furnished many details. A complete listing of members of all the committees mentioned, as well as a table of Florida legislation pertaining to the health center, may be obtained from the author.

References

1. Merritt, W.: A Century of Medicine in Jacksonville and Duval County, University of Florida Press, Gainesville, 1949.
2. Lippard, V. W.: Education for the Health Services in the State of Florida, Report of the Director of the Survey and Advisory Committee to the Committee on the Medical Survey, 1949.
3. Poor, R. S.; Maclachlan, John M., and Maloof, L. J. (ed.): Planning Florida's Health Leadership, University of Florida Press, 1954. Volumes I-V of the Medical Center Study Series.
4. Poor, R. S.: Meeting the Health Needs in a Southern State. Florida, Southern M. J. 47:174, 1954.
5. Poor, R. S.: The Objectives and Programs of the J. Hillis Miller Health Center, Economic Leaflets (Univ. of Florida) 14:1, 1954.
6. Harrell, G. T.: J. Hillis Miller Health Center, The Florida Alumnus, Spring, Fall and Winter issues, 1954.
7. Harrell, G. T.: The University in Medicine: Concept of the New Program at the University of Florida, J.A.M.A. 161:700, 1956.
8. Harrell, G. T.: University of Florida College of Medicine. J. Florida M.A. 45:296, 1958.
9. Harrell, G. T.: University of Florida College of Medicine, J. Florida M.A. 46:581, 1959.
10. Senate Bill No. 306, 1943: An act creating a University of South Florida whose purpose shall be to establish a School of Medicine, Pharmacy and Dentistry; not exact sum appropriated. Later repealed.
11. Senate Concurrent Resolution No. 3., 1945: Florida Citizens' Committee on Education is to make a survey and study of the State's system of higher education.
12. Mrs. J. Hillis Miller: personal communication to the author, May 20, 1965.
13. House Resolution 43 and Senate Resolution 16, 1947: Authorizing survey of medical school needs.
14. Senate Bill No. 329, 1949: An act to create and establish the School of Medicine and Nursing at the University of Florida; no monies appropriated.
15. The members of this Medical Advisory Committee other than William C. Thomas Sr., M.D., chairman, were Clyde O. Anderson, M.D., St. Petersburg; Herbert L. Bryans, M.D., Pensacola; Turner Z. Cason, M.D., Jacksonville; Charles J. Collins, M.D., Orlando; Julius C. Davis, M.D., Quincy; Frederick K. Herpel, M.D., West Palm Beach; Edward Jelks, M.D., Jacksonville; Norval M. Marr, M.D., St. Petersburg; David R. Murphy Jr., M.D., Tampa; Eugene G. Peek Sr., M.D., Ocala; Shaler Richardson, M.D., Jacksonville; William C. Roberts, M.D., Panama City; William M. Rowlett, M.D., Tampa, and Donald W. Smith, M.D., Miami.
16. Senate Bill No. 71, 1951: An act authorizing the Board of of Control to pay to the first accredited medical school in Florida $3,000 per year per student or $225,000 for the next two years (Refers to the University of Miami School of Medicine). Also, $100,000 was appropriated for the purpose of drafting plans for building and erecting and establishing a state medical school in Florida.
17. Senate Bill No. 21, 1955: An act appropriating $8,600,000 for construction of a teaching hospital.
18. House Bill No. 192, 1957: An act designating the University of Florida, Gainesville, as the site of a school of dentistry; no monies appropriated (Troy Peacock of Marianna introduced this bill).
19. Senate Bill No. 338, 1957; An act appropriating monies for the State of Florida provided $1,451,000 for construction of a pharmacy wing.
20. Barrow, M. V.: The Birth and Maturation of a New Medical School: the University of Florida College of Medicine, J. History of Medicine and Allied Sciences, 23:173, 1968.

Dr. Barrow, University of Florida College of Medicine, Gainesville 32601.

Life in the Spanish Colonial Hospitals in The Late 18th Century

William M. Straight, M.D.

One of the great lessons of history is humility. Recently, in seeking information about the practice of medicine in the Spanish colonies of the New World, I was struck by the similarity of the customs practiced in the royal hospitals of the Spanish colonies as illustrated by a set of regulations that were published in 1776.

These regulations, compiled by Senor Don Nicholas Joseph Rapun, Knight of the Order of Santiago of His Majesty's Council, Intendent-General of the Royal Army and of the Royal Treasury of the Island of Cuba, were published by royal decree in 1776. They were designed for the operation of the royal hospital in Havana and of similar royal hospitals throughout the new world. Whether these regulations were actually practiced in the royal hospital at St. Augustine during the second Spanish period, we do not know, but they do serve to give us a glimpse of the everyday life in hospitals similar to the one in St. Augustine.

Dr. A. P. Nasatir discovered a copy of these regulations in the Archivo General de Indias at Seville, Spain and has translated those parts of these regulations that deal with the staff organization and the equipping of the hospital. This article represents a resume of these regulations as published by Dr. Nasatir in the Annals of Medical History, November 1942.

Comptroller

The comptroller was the hospital administrator of that day and ultimately responsible for everything that transpired within its walls; ". . . he will be responsible for whatever faults . . . he must not dissimulate anything and must promote whatever is applicable to the better care and assistance of the patients, as well as to the greatest economy of the royal treasury."

He is required to scrutinize all requisitions and authorize them if he deems it wise; to verify all food slips; audit statements; keep a watchful eye on all equipment lest it be surreptitiously removed; see that utensils, equipment and clothing are properly cared for; authorize immediate admission of emergency cases; see to it that there be no default of the spiritual or corporal administration to patients; "have punished patients who become intoxicated because they are prejudicial, either disturbing the patients or falling asleep and failing their obligations, or now overthrowing the good method and order which the hospital must have"; inspect the food; accompany physicians and surgeons on rounds; discharge personnel who do not perform properly; watch over the religious life of the employees; check on the cleanliness of the hospital and see to it that no one cuts the hair of patients without the express orders of the physician or head surgeon, lest the patient seek this "with the object of not combing themselves, for which purpose they give headaches as a pretext, and other times when they have good hair, the subordinates solicit it for their particular purposes."

Receiving Clerk

The receiving clerk is charged with keeping account of the admissions, the vital information on all patients, the day each patient departs and for signing appropriate reports.

Steward

The steward is responsible for all expenditures and measures to insure good business management of the hospital. In addition, the conduct of the kitchen is his specific responsibility.

Chaplain

The Father Chaplain is to visit each patient upon admission and exhort him to confession lest the patient's illness become serious and benumb the senses before this has been carried out. The Holy Eucharist will be administered

immediately to seriously ill patients "in order to overcome the snares of the common enemy." The point is made that the physician's prognostications are not to be entirely relied upon and the priest must be prepared to use his own judgment as to the seriousness of the case. He is also charged with the care of the vestments and other religious items, the religious instruction of the servants of the hospital and it is suggested that he learn French as this is a universal language.

Physician

The physician is required to see his patients twice daily and enforce "silence and tranquility" among his entourage during these rounds lest one of his subordinates misunderstand an order. He will see that the medicines are properly made and administered at the proper hour. Without letting the patient know what he is about, he must "endeavor to know if the bread, meat, wine and other food have some defect which may be harmful." He must remain on good terms with others of his faculty as well as with the head surgeon. There must be no shifting of patients between surgeon and physician because of disharmony between these men. When surgical patients also have medical diseases, the physician will visit them on the surgical wards. The physician shall also visit "all those who are in rooms stamped with venereal disease" although the primary care of these patients is assigned to the surgeon. Finally, it is the physician's responsibility to "separate those who have contagious diseases . . . in order that . . . the others may not be contaminated."

Surgeon

The head surgeon also will make visits on the patients twice daily again maintaining silence and order in his retinue. Specifically, on these rounds he will not permit the practitioners "to converse, smoke, or do other things which may perturb the idea which they carry." He will ascertain that his previous orders have been followed and the medicines administered are good. He will direct the administering of all treatments and will "adapt himself to what the country offers, and not try to practice it (surgery) under the same rules as in Paris, Mompeller (Montpellier, France) and other European cities . . ." He will not prescribe remedies that cannot be had in the hospital. He will call in the physician and consult with him in all appropriate cases and will diligently separate "the infected ones to their respective rooms" and visit them daily. The surgical problem cured, if the patient is in need of further medical attention the surgeon "will order that they be sent to the room of that faculty." He will notify the physician when he plans to give mercury treatments for venereal disease so that the physician may send any patients he may have on his ward in need of these treatments. "When he must make a major operation (like an amputation, a trephine, a *Talla* [bladder operation] and others of this nature) he will discuss this with other physicians for the best decision and he will arrange for the practitioners to be present" so that they may be instructed. He will also arrange for their presence "whenever there is a dissection of some corpse. . . ."

Head Apothecary

The head apothecary will select medicaments and be knowledgeable in the mixture, collection, reposition and durability of the simples (medicinal herbs or plants) and method of titrating the simples and compounds. He will see to it that the simples are gathered at the proper time and extracted without delay. When necessary he will order drugs from Spain or the kingdom of Mexico. He will see to it that the proper apparatus for processing medicaments is on hand. He will order medicines which spoil easily to be made fresh daily and shall select the coolest place to store syrups and other medicines which ferment with heat. He will be ever on guard lest medicines be improperly appropriated and will send accounts of expenditures in his department to the comptroller on request.

Subordinate Apothecaries

The subordinate apothecaries are charged with preparing "all kinds of internal medicaments." They will issue "a slip of paper for the medicament and number of the bed of the one to whom it is to be given in order that this slip of paper when placed on the jars or cups where they (the medicaments) are to be put, there will be no confusion in distributing them."

Practitioners

The head practitioner appears to have been what we would call the chief resident. He is charged to carry out the orders of the comptroller, head surgeon and physician. He is responsible for the mistakes of the "younger prac-

titioners." In turn the younger practitioners "will obey him [the head practitioner] without contradicting him whatever he orders." He assigns the work among the younger practitioners "according to the intelligence of each one," and he is admonished to treat them with civility and gentleness. It is his responsibility to treat patients "as soon as they arrive at the hospital if the accident demands it," and to notify the physician and surgeon of what he has done on their return. If the illness is urgent or requires some arduous operation "he will inform them properly at any hour that it may be preformed in opportune time." The younger practitioners must perform the treatments ordered "like bleedings, vesicatories, cataplasms, mustard plasters, frectaciones [sic], fomentations, compresses, collyriums, gargles, mouth washes, dry and moist cuppings . . . it being likewise under their charge that the enemas be applied by the nurse."

Wardrobe Keeper

The wardrobe keeper collects the incoming patients' clothes and properly labels them. Upon admission the patient removes all clothing and dons a long-sleeved nightshirt which reaches below the knees. The point is made that by leaving their own clothing on "they are apt to bring some insects which multiply excessively and inconvenience not only the patients but also the servants of the hospital." The wardrobe keeper also sees to it that all "sheets, cloth and wool of mattresses, shirts, rags, rollers, surgical bandages and pillow cases are laundered and stored for further use." He is instructed to segregate "the sheets of consumptives, of those suffering from the malignant itch, and of scurvy patients," and to see to it that these sheets as well as the shirts of those patients are laundered separately.

Orderly

The *cabo de sala* (orderly) is responsible for the cleanliness of the rooms "and for this he will start with the chamber pots or services at four o'clock in the morning in the summer and at five in the winter in order that when the physician and head surgeon arrive they will find this duty performed, throwing lavender fumes or other aromatics as soon as this is concluded." The lavender fumes were not only in deference to the olfactory sensibilities of the medical staff but also were designed to counteract the evil effects of the noxious emanations of the chamber pots and those from patient's bodies. After visitation by the physician and surgeon and after breakfast has been served, he is to order the nurses to sweep the floor and clean the room. This procedure is done after each meal. The orderly will see to it that the rations are distributed in his presence and will check his memorandum (inscribed at the time of the physician's and surgeon's visit) to make sure that the patients get their prescribed diet. He will also see to it that each patient has a pitcher of water a half hour before meals, but he is not to leave water in easy access to the patients between meals "for its easy access would be harmful to many." He will also be "a vigilant caretaker that the nurses nor any one else introduce anything to eat or drink because this results in their ailments being increased . . . and when he knows or suspects that patients have raw brandy, wine, chili or any other kind of eatable in their beds he will inform the comptroller . . ." He will prohibit all kinds of games in the infirmary so that idlers won't clutter the hospital and so that the patients won't be out of their beds. "He will not consent that two lay down in one bed with the pretext of being a relative, friend or compatriot but that each one occupy his own . . ." He will also see that patients don't exchange rations.

The orderly will see to it that at least weekly the floors are washed, mopped and dried with sponges. He will see that the nurses clean and polish all utensils. He must see to it that the nurses "let out the fumigation" (sprinkle lavender and other aromatics) at the proper times, not when officials come to visit the hospital "in order to hide their [the nurses] scanty cleanliness from them with this odor. The purpose of fumigation is only to destroy corrupt materials from the atmosphere of the rooms, it being the siesta when it becomes most impregnated with the exhalations from respiration, unconscious perspirations, salivas, urine and other excretions." He is to order fumigation an hour after dark, in the morning after the chamber pots have been cleaned and a short while after closing the windows for siesta. In addition to these times, if a chamber pot is accidentally broken or overturned and after dressing malignant ulcers, fumigation will again "be let out." He will inspect the "chocolate maker" and other serviceable vessels if they are copper to make sure "they are well tinned" lest they "cause fatal consequences with their verdigris."

Rule and Order

Under a section entitled "Rule and Order" the decorum of the visit of the physician and the surgeon is carefully spelled out. Both are expected to make rounds "in their respective rooms" at five in the morning and three in the afternoon during the summer and at six in the morning and two in the afternoon in the winter. Upon the arrival of these gentlemen at the hospital, a bell is tolled three times to assemble the personnel who make rounds with them. The physician is accompanied by "an apothecary, a practitioner of surgery, an orderly and a nurse with a light." The first three of these are to carry memorandum books in which the orderly makes note of each patient's diet, the apothecary of the internal medicaments and the surgery practitioner "all which the physician corresponding to surgery may order (such as bleedings, blister plasters, their [sic] treatment, mustard plasters, frectaciones, fomentations, compresses, collyriums, cataplasms, poultices, linaments, enemas, dry and moist cuppings, gargles, mouth washes and all the rest belonging to topical application)."

The head surgeon is accompanied by the head practitioner, an orderly, a surgery practitioner, a druggist and a nurse with a light. The members of his entourage also carried memorandum books in which they note the same information that the respective member of the physician's team did. As each entourage goes from bed to bed, the orderly, apothecary and practitioner are expected to inform the physician or surgeon of what had been ordered the previous day. The physician or surgeon then determines if previous orders had been properly carried out and if a change of orders is indicated. He then dictates his orders for that day and at the end of the rounds, the orderly, apothecary and practitioner present their memorandum books for the physician or surgeon's signature. The head practitioner is expected to make another round at nine in the morning and at five in the afternoon each day to make sure that "the topical applications which the head surgeon might have ordered" have been carried out.

Diet

Several pages of the regulations dealing with diets are given but it is beyond the scope of this paper to go into these. Suffice it to say that these diets lean heavily on beef, chicken, bacon, lard, bread and chick peas. The "Ordinary Ration" (regular diet) for one day consisted of "a pound of fresh beef, with bone, one ounce of bacon, another of chick peas, 14 of bread and one-half ounce of pork lard. . . ." Breakfast consisted of a soup made of two ounces of bread and one-half ounce of lard; lunch and supper each consisted of eight ounces of beef, one-half ounce of bacon, one-half ounce of chick peas and six ounces of bread.

Utensils

Among the most interesting sections of these regulations is the section entitled, "Utensils Which Are Needed and Should Be Ready for the Service of the Hospital." Beds are either "leather cots" or of boards. If a leather cot, it is covered with "a wool mattress or a sack filled with straw, grass or other similar material according to what the country supplies." Each bed is supplied with a pillow of the same material as the mattress, "two sheets of fine Brabant linen or burlap" and a pillow case of the same material. In the event that the physician believes that a mattress might be harmful "in the rigorous month of the spring," the mattress may be replaced with a thick matting of reeds. The bed shall have a covering of wool, flannel, "fresada" or other equivalent material. Some sheets and pillow cases of the Rouen-type of linen shall be kept ready in case there should go to the hospital some person whom it is necessary to distinguish from the rest because of his circumstances.

"A pot with a cover shall be provided for each two patients for the greatest cleanliness, decency, stability, and rest of the patients which would not be obtained with the uncovered pot . . ." Apparently the pot was set into a cabinet or "case" on which the patient seated himself much like our present day commode chairs. Such a case is placed between the first and second beds, the third and fourth beds and so on. The beds are spaced "at a proportionate distance in order that they [the patients] may manage and seat themselves freely on the cases." The case was not only more aesthetic but also prevented "running the risk of their [the chamber pots] easily breaking when they are resting on them and abuse the patients."

A bedside stand or shelf is placed with each bed to hold such items as the water pitcher, a plate, a cup, a wooden spoon, a burlap or linen napkin, "a jar to take medicine" and a card marking the number of the bed.

Each ward ("room") shall have an "escafeta" with which to throw out lavender fumes, a chocolate pot, a lantern or small lamp to provide light at night, a brasier to provide heat or to heat medicaments (the coal in the brasier is to be burned outside the ward as the fumes given off are noxious; it is to be brought inside "after the smoke has disappeared"), tin candlesticks, a towel, a broom and a frail (trash basket). Each ward shall also have an "apparatus" (cabinet) to contain an "ungentarium" of tin plate with eight divisions to contain various ungents, spirits of wine, tincture of myrrh, catholic balsam and so forth as well as bandages, compresses, thread, needles, pins, a syringe and a tin plate used "to heat the small irons" (cauteries). Also in the apparatus must be a razor and tin plates to heat cataplasms. The cabinet is kept closed for the sake of cleanliness and to avoid "deficiencies which would be experienced otherwise." The hospital will also have available "boxes for fractures," splints, gauntlets, paste board, tablets and tow. "Likewise there will be a few beds with holes in order that those who have fractured legs or thighs may stool without moving."

Large portable open lamps are to be kept in readiness to place at the bedside of dying patients. "These are composed of a stick one and a half yards long, of about four to five inches in circumference with its foot at the base and an iron support above one third on all sides more or less on whose edge shall be placed a back to place the printed image of Christ." A small lighted lamp is to be placed in the middle of the bed plate and a nail in the center of the stick to hang the "pot containing holy water and the hyssop which the Father Chaplain will use at the proper time."

Reference

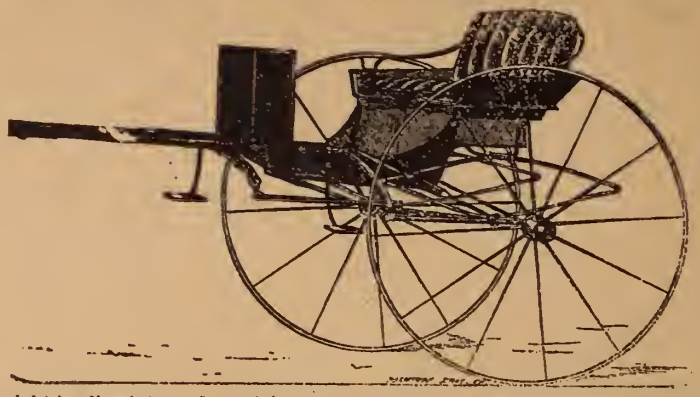
1. Nasatir, A. P.: Royal Hospitals in Colonial Spanish America, Annals of Medical History, 4:481-503 (November) 1942.

Dr. Straight, 550 Brickell Avenue, Miami 33131.

PERFECTION AT LAST!

A TWO-WHEELED vehicle that will ride as easy as a FOUR-WHEELED one. Absolutely free from horse motion. Adjustable to heavy or light load, large or small horse, by a patent devise in the shafts.

HEMPSTEAD, TEXAS, June 16, 1883.
W. R. CHURCH: *Dear Sir.*—The cart has been tried by me, and is satisfactory in every particular. I will not hesitate to recommend them, not only to physicians, but also to any and all persons having much traveling to do.
Yours, etc., P. S. CLARKE.



MADRID, IOWA, June 16, 1886.
W. R. CHURCH: *Dear Sir.*—I would say that I have used one of your Road Carts for six months, and I don't think they can be beat for easy riding. I sold the cart two months ago to a livery man and he thinks they can't be beat for running about.
Yours truly, C. F. BENICO.

Special rates of freight to all points, and special offer to introduce in new territory. Send for illustrated price list.
Address. THE CHURCH CART MF.'G CO., ST. PAUL, MINN

Reprinted from the Weekly Medical Review, November 8, 1890.

Farr's Improved Flexible Uterine Supporters, etc.



No. 1 Improved Uterine Supporter. Price, $5.00 each.



No. 1 Menstrual Receptacle. Price, $3.00 each.

Automatic Distendor and Irrigator.



Closed.



Opened.
Price, $2.00; with Syringe, $2.50.



Price, $2.00 each.



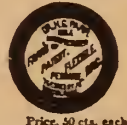
Patent Pelvic Uterine Supporter. Price, $2.00 each.

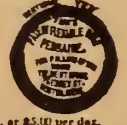


No. 2 Uterine Supporter. Price, $4.00 each.

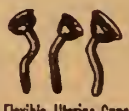


No. 2 Menstrual Receptacle. Price, $2.00 each.





Price, 50 cts. each, or $5.00 per doz.



Flexible Uterine Cups. Price, $2.00 each.

In Ordering send money by P. O. Order, Registered Letter, Check or Draft.

MY GOODS ARE THE BEST IN MARKET.

SATISFACTION GUARANTEED.

Dr. H. G. FARR, Sole Manufacturer, 75 Essex St., Boston, Mass.

P. S.—Send for Descriptive Circular.

Mention the Journal. 4-85-12t

Reprinted from the Atlanta Medical and Surgical Journal, September, 1885.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101


SUNDAY
MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY

Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

works the way a woman thinks

by weekdays...not "cycle days"

Whether it be "shopping day," "bridge day" or "housecleaning day," a woman is accustomed to thinking in terms of days of the week rather than in "cycle days." Ovulen-21 lets her remember her natural way. Once established, her starting day is always the same day of the week... because it is fixed at three weeks on — one week off and is independent of withdrawal flow.

The same Ovulen in the same low dosage... with the same low incidence of side effects and the same high degree of protection against pregnancy.

Note: Ovulen remains available in the familiar round Compack for those women who may wish to continue to use the traditional 20-day schedule. Be sure to specify Ovulen-21 to assure each new patient of the advantages of the new *Three Weeks On—One Week Off* schedule. She might appreciate your budget-minded authorization for a six-month supply (five Refills).

Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

SEARLE

Before prescribing see Detailed Product Information.

G.D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

three weeks on...one week off

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-1

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®

(iron dextran injection)

IN BRIEF: ACTIDN AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPDSITIDN: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CDNTRAINDICATIDNS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Easy on the Budget...
Easy on the Mother

Tablets & Elixir

For Iron Deficiency Anemia

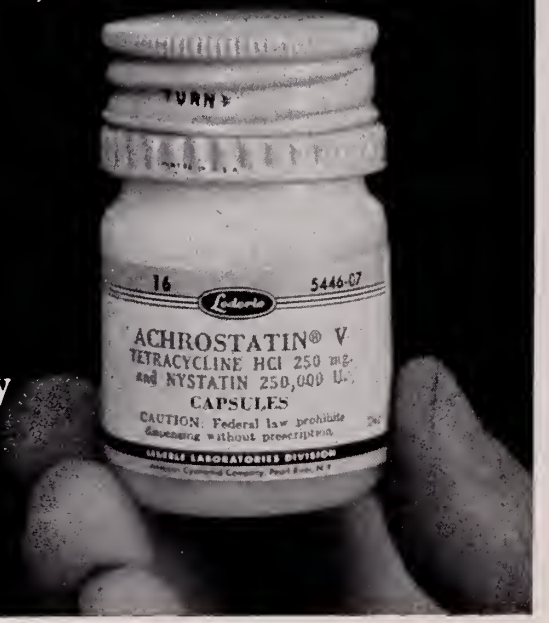
BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS Fergon®
brand of FERROUS GLUCONATE

The lowest priced tetracycline-nystatin combination

ACHROSTATIN® V Capsules

Tetracycline HCl 250 mg /Nystatin 250,000 units



One of the 31 useful dosage forms in the ACHRO Family -the First Family of Tetracycline

Lederle

328-8/6094

From the Editor

Franz Stewart

History

If this were a chronicle of actions taken, we would have something, accurate perhaps, but not history. There must be human feeling, motivation, a sense of place in moving time.

Those of us who live in Florida, even the shortest time, become a part of life on these spits of sand, rolling hills, and dry turned ocean floor. Our moment stands forever and leaves its mark to find a place in the scheme of things.

Action demands attention to the moment, but action comes from courses of the past which move on to make the future. The August issue is our special chance for history. A hint to help us find a place in moving time—history.

History

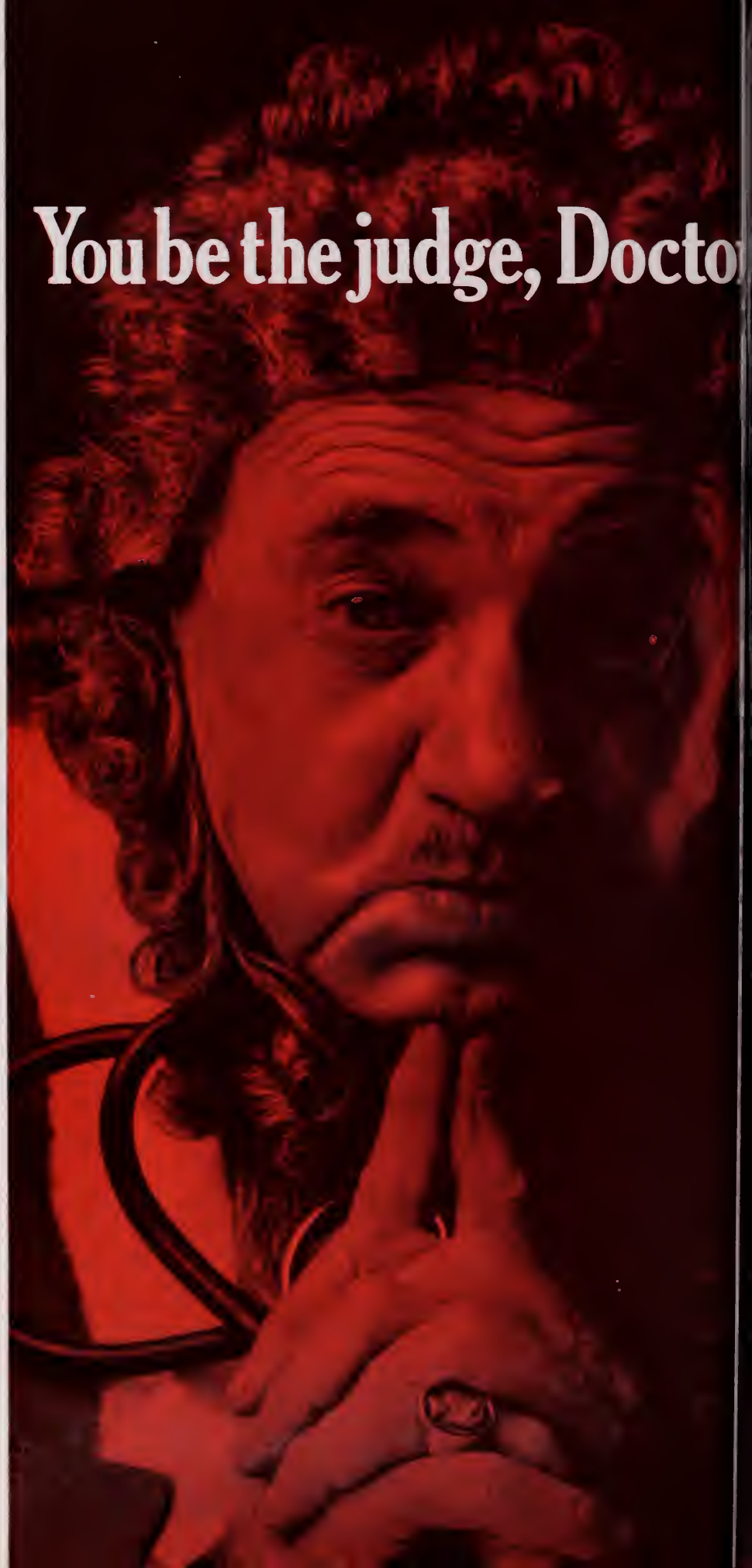
In Florida, in August, in 1968! Here is history! The events, the plans, the hopes that come from near old Florida Light, may have little to do with Indians, or helmeted Spaniards, but surely cast a sparkling flare across this nation and the world. The reading of your newspaper, is the reading of history.

Time may mark the meeting as a milepost, but the course of events before and after will measure the power of the flash and mark the measure of the names you hear. That remarkable institution! The American national convention of political parties. It is our first, for Florida, you know.

Editors

There is quite a question as to why they should be, but that's for readers and writers to ponder, and not for me. The staff, I'm sure, would much prefer that editors were all deposited safe and secure on some island, preferably distant by many years.

But then there comes along an August issue and a History Section, and what would this be without the searching, editing, and writing of Bill Straight, History Editor.



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

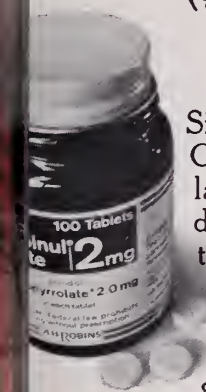
Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?

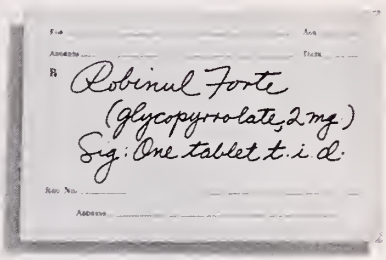
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) d good acceptance among numerous physicians, y others just didn't seem to want to give it a try, ably because the anticholinergic they were al- y using was giving acceptable results.

wever, we believe you'll agree there's always n for a better anticholinergic. This is why we're ng you to give Robinul Forte a fair trial. Robinul e exerts a highly specific antisecretory action and ked inhibitory effect on intestinal tone. We're con- ed you'll agree that this is indeed an outstanding when you observe its outstanding suppression of r symptoms. Furthermore, it is unique in that it ces intestinal tone, yet has little or no effect on stalsis. In addition, the incidence of the more ersome peripheral side effects is low.

longer does the physician have to look for extreme mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

A Modern Psychiatric Hospital . . .

This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

Member American Hospital Association
Medicare Provider

Florida Medical | comment

Florida Individual Responsibility Program

Dr. Irving Hall was requested to help us present information concerning this program. Dr. Carl N. Reilly has responded to his request with this comment—Ed.

The House of Delegates of your Florida Medical Association established the Florida Individual Responsibility Program (FIRP) by a resolution adopted during the 1967 session. The House reaffirmed its support of this program during the 1968 meeting by passage of Resolution 68-15 which reads as follows:

> Be it RESOLVED, By the House of Delegates of the Florida Medical Association, that the Individual Responsibility Program Committee is re-affirmed and continued, and further be it
> RESOLVED, That the Board of Governors of the Florida Medical Association is instructed to continue and promote the principles of the Individual Responsibility Program.

During the intervening year, a committee under the chairmanship of Dr. Irving Hall, through consultation with states in which Individual Responsibility Programs are already in progress, established FIRP and prepared the materials for this program. These materials are 1) statement of recommended policy; 2) attending physician's statement; 3)sample letter to an insurance company by a medical society to explain our position on the FIRP forms; 4) sample letter to an insurance company by doctor to whom FIRP forms are returned; 5) Briefs, advance copy No. 208 entitled "Florida Individual Responsibility Program," and 6) poster entitled "FIRP Policy Notice."

In April 1968, a set of these materials—including the FIRP Handbook of Procedure for the Physician and His Office Staff—was mailed to each FMA member. An order form is included in each FIRP Handbook.

The purpose of this program should be clearly understood by every member of the Association. We cannot emphasize too often that this is a *voluntary* program; however, its success depends upon adoption of FIRP by a majority of the FMA members.

The primary objective of FIRP is to do away with any relationship of an economic nature between the physician and the insurer; this is accomplished through voluntary refusal of assignments. In this way we may avoid any legal or economic obligation to abide by the fee scales or relative value scales which might be employed by the insurer. There is no intention to deprive any insurance company or agent of the necessary technical information for settling a claim, nor to cause the patient any hardship or loss through such a settlement. We will simply insist upon confining ourselves to the medical aspect and upon denying to any third parties the opportunity to influence this part of the relationship. Our charges for medical services must never be adjusted to conform to any pattern of insurance benefits.

For medical information, physicians then will be responsible only to their patients, and such information will be sufficiently presented to each patient, at his specific request, on a one page form of our own design. Then, if he so desires, the patient may make this information available to any third party he chooses, whether it be to seek some form of reimbursement or for any other reason. Physicians and their office personnel thus will be relieved of the burden of completing the many and various forms offered for such reporting by the various insurance companies, and will readily become proficient in preparing the short, but adequate, FIRP form.

Some may question whether or not the insurance companies will find the FIRP form satisfactory, and we are happy to report to you that general experiences in this matter have been good. In Texas, where such a plan is now being utilized, 95% of the companies contacted have agreed that the form is, indeed, sufficient for purposes of claim settlement. We foresee that other companies will also concur, as has happened in Texas, and this problem may never present itself. If the FIRP form is used in strength, it is anticipated that insurance representatives will agree to our form.

By dealing with only the patient in this situation, we will enable ourselves to escape being



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

caught in the middle in the matter of any possible disagreements between insurance companies and patients, a situation in which we sometimes found ourselves when accepting assignment of benefits. In addition, the program, in its simplicity, easily can be understood by patients, who will soon learn to handle their insurance claims with far less than the accustomed frequency of misunderstandings and delays.

The patient will become accustomed to the two separate relationships involved in an insurance-covered medical expense, one with his physician and the other with his insurer. The two will then be kept in their proper perspective and intrusion into medical practice by third parties can be avoided. Both medicine and insurance are obligated to the patient, and each should discharge its obligation fully and stop at that point. No need to negotiate will exist under FIRP, as medicine and insurance will not be obligated to each other.

Participation in the Florida Individual Responsibility Program is voluntary in keeping with the freedom of choice that is every man's right. This same right should apply to the patient in choosing his insurer on the one hand and his physician on the other. Thus, there is no need for doctors and insurance companies or agents to choose among each other. They should not be related.

We hope to have a monthly presentation of FIRP in your JOURNAL and a section devoted to questions and answers on this subject.

CARL N. REILLY, M.D.
PUNTA GORDA

Pact or Placque

Oh Siamese twins, cerebrum and cerebellum
Forever imprisoned in my own calvarium
Through biochemical magic you give me perception
Memory, understanding, emotion and direction
Wonder of wonders the things you make me do
Some delightful, some good, and some I rue
By thoughts and actions you send me everywhere
While you sit in my skull under all that hair (?)
And all you ask so that you may not die
Is a constant and plentiful blood supply
For should this fail, your duty you'll revoke
And I will suffer what is known as a stroke
So let's make a pact, your robot I'll remain
If you'll tell my vessels from thrombi to refrain.

A. C. GALLUCCIO, M.D.
HOLLYWOOD

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

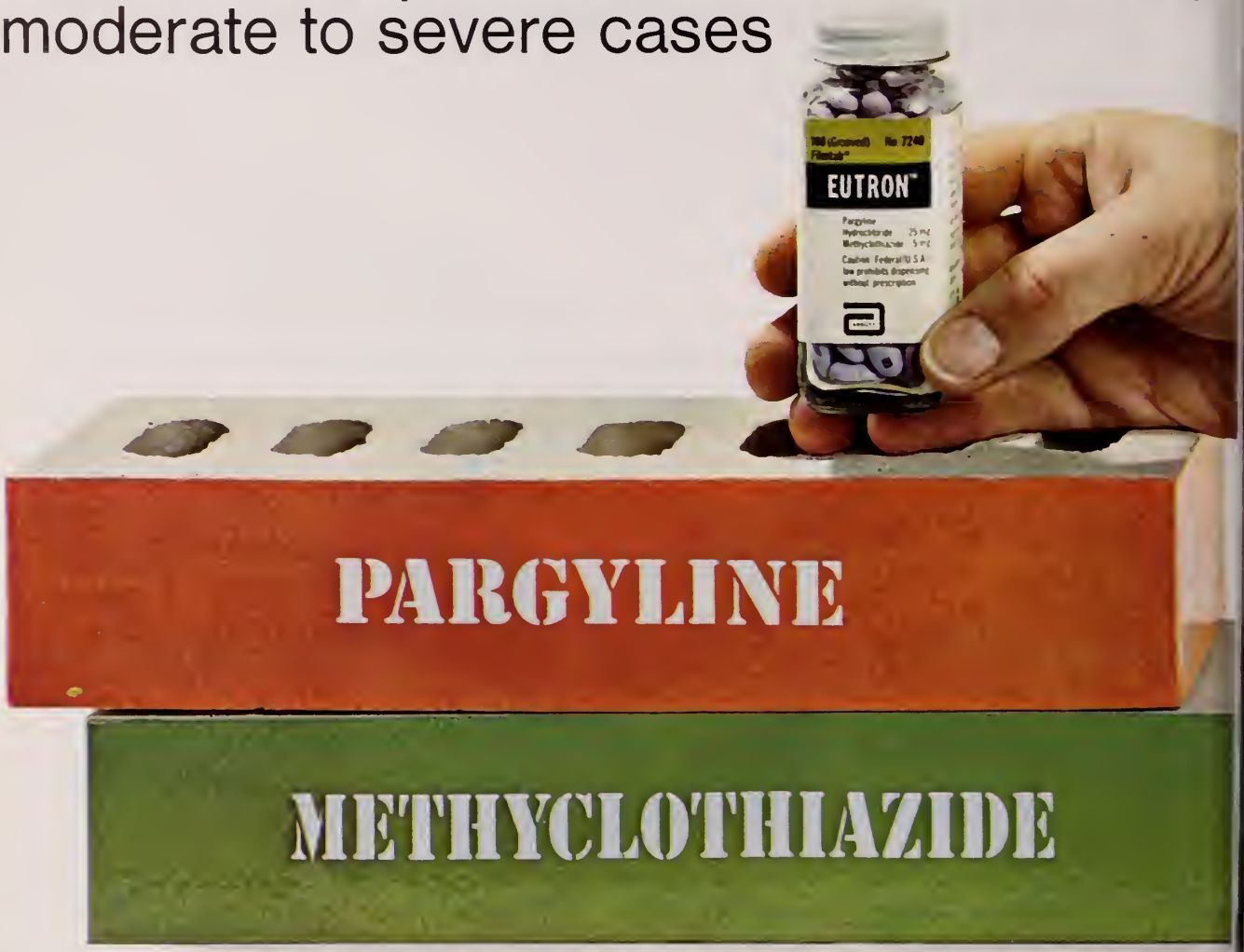
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

80109-

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

ABBOTT

TM-TRADEMARK



pinworms
n this
amily?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

...and if hygienic measures alone are not enough...?

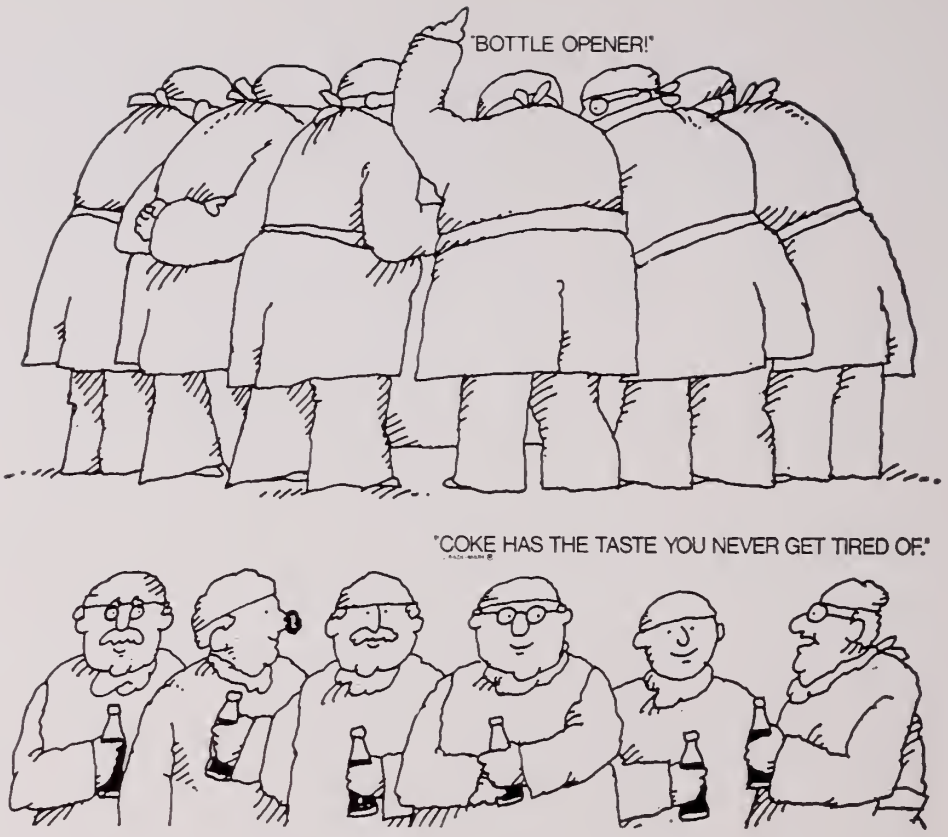
when examination reveals pinworm infection, estimated to occur in from ⅓ to more than ½ of all American children from every social level, an increasing number of physicians favor treatment with a single, economical dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

33668



"COCA-COLA" AND "COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

Dedication of the J. Y. Porter Marker

He was a pioneer in preventive medicine and his merited achievements, rendering living conditions better in the state, are now history. As long as there is a Florida, his memory will be cherished.

Editorial: Joseph Yates Porter, J. Fla. M.A. 13:272 (May) 1927.

Despite drippy skies some 56 of Key West's most prominent citizens assembled on the wide veranda of the old Porter home at 429 Caroline Street, Wednesday, May 8, to pay honor to Dr. Joseph Yates Porter (1847-1927). The occasion was the dedication of a historical marker by the Florida Medical Association honoring the achievements of this outstanding Florida citizen.

Dr. Porter, an outstanding epidemiologist of his day, was the first state health officer and served our state for 28 years. During his term of office yellow fever was eradicated and other epidemic diseases such as malaria and tuberculosis were brought under control.

First to address the group was Dr. José T. Sanchez Jr., President of the Monroe County Medical Society. Dr. Sanchez brought a word of greeting from his colleagues, many of whom were present and introduced the honorable Kermit Lewin, mayor of Key West. Mayor Lewin welcomed the assembled gathering and expressed appreciation for the honor being bestowed upon the city by the recognition of one of their prominent citizens by the Florida Medical Association. These comments were followed by greetings from Dr. W. Dean Steward, President of the Florida Medical Association and Dr. Eugene Peek, president, State Board of Health.

The audience then was addressed by Dr. Wilson Sowder, State Health Officer, who is also Dr. Porter's biographer. Dr. Sowder gave an interesting account of Dr. Porter's personality with amusing references to Dr. Porter's thoughts on the subject of medical economics. For example, in 1913 at a time when the state was paying for the care of smallpox victims who were medically indigent, Dr. Porter became incensed at a physician who submitted a bill for $17.00 for the care of three smallpox victims over a period of several

Florida Medical Association Officers and Council Chairmen

Officers

Jack Q. Cleveland, M.D., Coral Gables, President
Henry J. Babers Jr., M.D., Gainesville, President-Elect
Irving E. Hall Jr., M.D., Bradenton, Vice President
James T. Cook, M.D., Marianna, Speaker of the House
Charles K. Donegan, M.D., St. Petersburg, Vice Speaker
Floyd K. Hurt, M.D., Jacksonville, Secretary-Treasurer
W. Dean Steward, M.D., Orlando, Immediate Past President
W. Harold Parham, Jacksonville, Executive Director

Chairmen

James W. Walker, M.D., Jacksonville, Allied Professions and Vocations
John J. Cheleden, M.D., Daytona Beach, Judicial
Jere W. Annis, M.D., Lakeland, Legislation and Public Agencies
Jack A. MaCris, M.D., St. Petersburg, Medical Economics
James M. Ingram, M.D., Tampa, Medical Services
Richard C. Dever, M.D., Miami, Scientific Activities
William C. Roberts, M.D., Panama City, Special Activities
Joseph G. Matthews, M.D., Orlando, Specialty Medicine
Hawley H. Seiler, M.D., Tampa, Voluntary Health Agencies

weeks. The doctor pointed out that at least one patient got well. Dr. Porter, in response to this, had some testy words to say about a doctor who would gouge for such a tremendous fee. The highlight of Dr. Sowder's talk was the showing of a gold watch that had been presented to Dr. Porter by the Auxiliary Sanitary Service of Jacksonville in recognition for his outstanding assistance to the citizens of that city during the yellow fever epidemic of 1888. This beautiful, jewel incrusted watch not only gives the time by day but also gives the time by night through the use of multitoned chimes. This watch was presented to the Florida State Board of Health by Dr. Porter's grandson.



Mrs. Jessie Porter Newton, granddaughter of Dr. J. Y. Porter, welcomes those attending the dedication ceremony.

The final speaker was our lovely hostess, Mrs. Jessie Porter Newton, granddaughter of Dr. J. Y. Porter. She in turn introduced Miss Minnie Porter Harris, the other surviving granddaughter of Dr. Porter. Mrs. Newton told something of the history of the Porter house which was built in the early 19th Century. Finally, she invited us to partake of a lovely buffet and to visit in the Porter house and in her house, another early 19th Century structure which was two doors down the street.

Unable to attend was a grandson, Mr. W. Curry Harris.

WILLIAM M. STRAIGHT, M.D.
MIAMI



Pictured with the Porter marker are (from left) Drs. Eugene G. Peek Jr., W. Dean Steward, Jack Q. Cleveland, Wilson T. Sowder and William M. Straight.

FMA Executive Director Elected to National Office



W. Harold Parham, executive director of the Florida Medical Association for the past decade, recently was named president-elect of the American Association of Medical Society Executives. The election was June 15 at the group's 1968 annual meeting, held prior to the opening of the American Medical Association convention in San Francisco. He will be installed next year as the organization's 24th president.

AAMSE was established in 1946 as the Medical Society Executives Association, a name it carried until the present title was adopted in 1967. Its membership of nearly 500 consists of medical and lay executive personnel of national, regional, state and local professional medical associations. The objectives are largely educational in nature.

Educated in the public schools of his native city of Jacksonville, Mr. Parham attended the University of Florida and then Stetson University where he received a baccalaureate degree in 1949. He joined the FMA staff the same year.

Mr. Parham's military experience includes service with the U. S. Army airborne forces in Europe during World War II and with the Army medical service corps in Asia during the Korean conflict.

Prior to his appointment in 1958 as executive director, Mr. Parham held FMA staff positions as supervisor of the Bureau of Public Relations, assistant managing director and associate managing director.

He also currently serves as executive secretary of the Florida Medical Foundation, secretary of the Governor's Steering Committee on Health, executive committee member of the Florida Advisory Council for Comprehensive Health Planning, secretary of the Florida Advisory Council for Heart Disease, Cancer and Stroke, Inc. and as a director of the First Bank and Trust Co. of Jacksonville.

Mr. Parham's wife, the former Mary Copeland, is the daughter of a physician. They have two children.

FMA Science Fair Winner Captures National Honor

Miss Shelley Williams, the 17-year-old Melbourne High School senior who won the Florida Medical Association's first place award in the 1968 State Science Fair (see June Journal), went on to win one of the two top American Medical Association awards in the 1968 International Science Fair held in Detroit May 15-18.

Miss Williams' winning exhibit, "Genetic Mechanisms of Antibody Synthesis: An Investigation of the Template Mechanisms of In Vitro Lymphocyte Antibody Production," was displayed by invitation at the AMA's annual convention June 16-20 in San Francisco. Miss Williams was introduced to the AMA House of Delegates and honored at the AMA scientific awards dinner. The FMA officers visited the booth and Miss Williams later was the dinner guest of Secretary-Treasurer Dr. Floyd K. Hurt and Mrs. Hurt.



Dr. Jack Q. Cleveland, FMA President, and Miss Williams.

When the problem is only skin deep

USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



TUCKER HOSPITAL, INC.

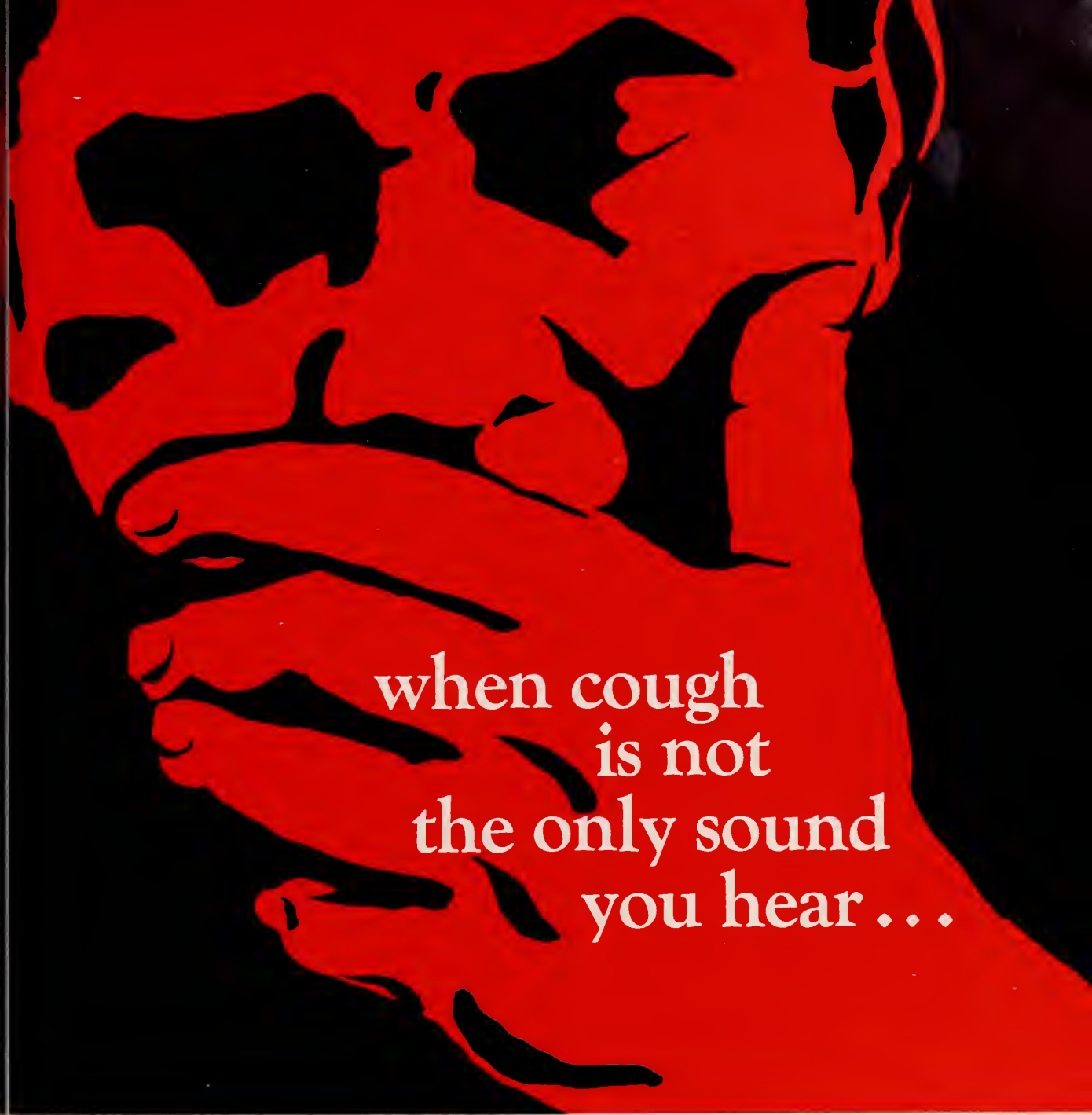
212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

Stamas

builds the OPEN FISHERMAN THAT LADIES LOVE

The new Stamas V-24 Tarpan is the world's only open fisherman with an enclosed tailet compartment. It also is the fisherman that is the eminently enjayable family-fun boat. With an 8 ft. beam, it can be trailered anywhere. The Stamas-designed vee hull gives yau a remarkably *level* and incredibly dry ride—at any speed and in any water. The 19 ft. cackpit is self-bailing, spacious, completely uncluttered. The center steering station provides 360° flybridge visibility, standing ar sitting. Standard equipment includes teak trim, rad racks, rad halders, self-circulating live bait wells, 120 mile range. The extra strength and stamina of Stamas hand lay-up fiberglas construction are standard equipment tao.

Write for name af nearest Stamas dealer and far new brachures an Stamas V-24 Tarpan, V-24 Clearwater, V-26 Americana and other models.

Stamas BOATS, INC.
Tarpon Springs, Florida 33589



Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

St. Francis Hospital Third Annual Medical-Surgical Seminar

Hospital Auditorium Miami Beach, Fla.

Wednesday and Thursday October 23-24, 1968

"Practical Aspects Of Pulmonary Diseases"

Maurice Segal, M.D., Director of Lung Station, Tufts University

1. Management of Patient with Acute Respiratory Insufficiency
2. Bronchial Asthma, Chronic, Acute Recent Management and Therapy

Edward A. Gaensler, M.D., Professor of Surgery, Boston University School of Medicine

1. Selection of Emphysema Patients for Surgery
2. Mechanics of Breathing, Normal and Abnormal

Asher Marks, M.D., Associate Professor of Medicine, University of Miami School of Medicine

1. The Many Faces of Sarcoid

Marvin Sackner, M.D., Chief, Division of Pulmonary Diseases, Mt. Sinai Hospital, Miami Beach, Florida

1. Interpretation of Arterial Blood Gas Analysis

Panels

1. The Management of Patient with Chronic Respiratory Disease
2. Management of "Status Asthmaticus"
3. Surgical and Medical Advances in Diagnosis and Therapy of Pulmonary Neoplasm

Approved for 8½ elective hours AAGP

Sessions

Wednesday and Thursday
October 23-24, 1968—2-5 & 8-10 P.M.

For additional information: Contact Seminar Office, St. Francis Hospital, Miami Beach, Florida

Telephone: 866-7741

No registration fee.

CONVENTION PRESS

2111 NORTH LIBERTY ST.
JACKSONVILLE, FLORIDA
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Thomas B. Slade — Fifty Years in Florida — J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 — P. O. Box 2580 — 1050 W. Adams Street — Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. ISAACSON, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: GP (AAGP) to join established GP in rapidly growing community. New 200 bed hospital. Write C-816, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Physician to do general practice with two established G.P.s for association and eventual partnership. 35 bed approved JCAH hospital soon to expand—with modern Professional Arts Bldg. and Northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER with Florida license wanted in Orlando area. Full time opening in county supported outpatient medical clinic. Regular hours, no nights or weekends. Starting salary $18,000; social security, paid insurance, retirement, other fringe benefits. Contact Victoria B. Vacha, M.D., 89 West Copeland Drive, Orlando 32806. Telephone (305) 241-4311, ext. 368.

WANTED: GP—mature, Florida licensed doctor for resort area. Guaranteed salary $34,000 annually. Medical Placement, 1371 Peachtree St. N.E., Atlanta, Ga. 30309.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

WANTED: Internist emphasis cardiology. Florida license required. No investment. Guaranteed salary $36,000 annually, Medical Placement, 1371 Peachtree St., N.E., Atlanta, Ga. 30309.

INTERNIST WANTED: To associate with established internist in greater Miami area. Terms open. Attractive fringe benefits. Large, active practice. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified to associate with two physicians in the greater Miami area. Salary open. Write C-845, P. O. Box 2411, Jacksonville, Fla. 32203.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd., W., Bradenton, Fla. 33505.

WANTED: Internal medicine practice opportunity for board eligible internist with subspecialty interest in Southeastern coastal community. Starting salary $21,000 first year with opportunity for full partnership. Write C-844, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

GASTROENTEROLOGIST WANTED: $20,000 to $32,000 to start, depending on experience and training with early full partnership. Contact James J. Traitz, M.D., 1160 Kane Concourse, Bay Harbor, Miami Beach, Fla. 33154.

ANESTHESIOLOGIST WANTED: Board certified or eligible to join group in private practice in South Florida. Florida license required. Write C-838, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST OR CARDIOLOGIST WANTED IMMEDIATELY to join well established group on Miami Beach. Excellent starting salary and full partnership offered. Contact Nathan N. Kimball, M.D., Professional Associates, 333 Arthur Godfrey Rd., Miami Beach, Fla. 33140. Phone 531-6755.

ASSOCIATE WANTED: For obstetrical and gynecological practice in Palm Beach, Florida in an active existing two man partnership. Board qualified or certified and has completed his military obligation. Florida license necessary. Contract Mr. Harold Kwart, Medical Business Consultants, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

INTERNIST board eligible or certified for expanding clinic in Palm Beach County. Gastroenterology film and fluoroscopy training desirable. Excellent hospitals. Academic, financial and personal satisfaction. Write C-822, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

WANTED: General practitioner or internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Guarantee $20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

WANTED: General practitioner or internist for an association and partnership. Busy practice in Surfside, Miami Beach, Florida. First year income $16,000 to $18,000. Three years to full partnership. Write S. Nelson Tippett, M.D., 9452 Harding Ave., Surfside, Miami Beach, Fla. 33154.

STAFF PHYSICIANS—2,400 bed psychiatric hospital with residency training program in psychiatry. Three vacancies on alcoholic, geriatric or psychiatric services. Salary $12,000 to $21,000. Forty hour week, ten days sick leave, three weeks vacation and retirement program. Contact R. L. Rollins Jr., M.D., Dorothea Dix Hospital, Raleigh, N.C. 27602.

WANTED: GP or General Surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

EMERGENCY ROOM PHYSICIAN: One vacancy at Broward General and one at North District hospitals. Florida license required. Minimum professional fee $20,000 per annum with annual review to $25,000 at end of second year. Regular 8 hour shift. Excellent employee benefit program. Contact District Director, North Broward Hospital District, 1600 S. Andrews Ave., Fort Lauderdale 33316.

G. P. OR INTERNIST WANTED: Unique opportunity. Beautiful exclusive area central Florida. Will introduce acceptable individual to patients. Open immediately, investment optional. Write C-841, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: E.N.T., internist (board qualified) or G.P. to associate with new group in new offices in central Florida community of 40,000. Terms negotiable. Write C-840, P.O. Box 241, Jacksonville, Fla. 32203.

WANTED: Emergency room physician in hospital; to join group of private physicians, 42 hour week, income $20,000 plus. Contact Bruce S. Webster, M.D., 89 W. Copeland Dr., Orlando, Fla. 32806. Phone 241-4311, Ext. 380 or 647-5728.

EMERGENCY ROOM PHYSICIANS: Wanted to join five man group; full time, no private practice allowed; fee for service, $20,000 annual guarantee. Florida license necessary; modern 500 bed hospital; 25,000 patients annually. Lakeland General Hospital is a teaching hospital with an active approved internship-residency program. For additional information write Sherwood D. Smith, Adm., P.O. Drawer 448, Lakeland, Fla. 33802.

situations wanted

ORTHOPEDIC SURGEON: Age 40, board certified, F.A.C.S., Florida license, eight years busy private Midwest practice, wishes to practice in Florida. Partnership in college town preferred. Write C-825, P.O. Box 2411, Jacksonville, Fla. 32203.

POSITION WANTED: Indiana University (AOA) radiology resident, age 30, military service completed, seeks radiology group position for July 1969. Have Florida license. Write C-846, P.O. Box 2411, Jacksonville, Fla. 32203.

PATHOLOGIST, CP and PA certified, 14 years department director 300 bed hospital. Director school medical technology. Radioisotopes licenses. Teaching challenge welcomed. Desire relocation South Florida (licensed). Available immediately. Write C-835, P. O. Box 2411, Jacksonville, Fla. 32203.

PERIPHERAL VASCULAR SURGEON, board certified, Florida licensed, desires partnership or group practice. Available July 1. Write C-833, P.O. Box 2411, Jacksonville, Fla, 32203.

practices for sale

FOR SALE OR LEASE: Active practice 21 years. Spacious 12 room modernly equipped establishment, new 62 bed hospital in Sebring, Fla. Contact Stanley K. Wallace, M.D., 32 N. Commerce St., Sebring, Fla. 33870. Telephone 385-8640.

real estate

FOR RENT: Medical office complete. New. Rent free to December 1968. Write Suite 111, 4800 N.E. 20th Terrace, Fort Lauderdale, Fla. 33301.

MEDICAL OFFICE FOR RENT: Excellent opportunity. Physician leaving area. 3 treatment rooms, darkroom, lab, carpeted private office, etc. Rental only $210 monthly. St. Petersburg, Florida 33703. Phone 526-3868.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

A COMPLETE BUSINESS SERVICE

Professional Management

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT since 1932 PM FOR PHYSICIANS AND DENTISTS

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. He's tired most of the time. Though there's nothing wrong with him organically, he suffers from general malaise. Lassitude has become his way of life . . . vague aches and pains his major concern.

Such a patient has entered the "Mediatric Age"—that stage of his life in which he's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support he's apt to need. MEDIATRIC is intended to help keep him more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period--Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		(Contains 15% alcohol†) †Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound

AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada 6838

Florida Organizations of Medical Interest Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association	Jack Q. Cleveland, Coral Gables	Floyd K. Hurt, Jacksonville	Bal Harbour, May 14-18, 1969
Florida Specialty Societies			
Allergy Society	Robert J. Brennan, Ft. Lauderdale	Meyer B. Marks, Miami Beach	(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)
Anesthesiologists, Soc. of	Henry J. Vomacka, Sarasota	George T. Edwards, Jacksonville	
Chest Phys., Am. Coll., Fla. Chap.	Harold C. Spear, Miami	Charles H. Lasley, Clearwater	
Dermatology, Society of	William W. Bruce, Winter Park	Arnold R. Goddard, Miami	
Gastroenterologic Society	Charles E. Aucremann, St. Pet'sb'g	James H. Johnson, Lakeland	
General Practice, Academy	Louis C. Murray, Orlando	William P. Clarke, Jacksonville	
Internal Medicine	William M. Straight, Miami	Robert L. Andreae, Ft. Lauderdale	
Neurology, Florida Society of	Richard P. Schmidt, Gainesville	James B. Perry, Ft. Lauderdale	
Neurosurgical Society	Jack W. Barrett, Miami	Howard C. Chandler, Jacksonville	
Obst. & Gynec. Society	T. Vernon Finch, Sarasota	Joseph W. Pilkington, St. Petersb'g	
Ophthalmology Society	Samuel T. Register, Clearwater	Charles F. McCrory, Jacksonville	
Orthopedic Society	Claude D. Holmes Jr., Miami	Albert A. Wilson, Tampa	
Otolaryngology Society	John H. Webb Jr., Orlando	James H. Mendel Jr., S. Miami	
Pathologists, Society of	David K. Davis, St. Petersburg	Wallace M. Graves Jr., Ft. Myers	
Pediatric Society	Richard G. Skinner Jr., Jack'ville	Thomas M. Brill, Gainesville	
Phys. Med. & Rehab., Fla. Soc.	Sterling H. Huntington, Coral Gbls.	Justine L. Vaughen, Orlando	
Plastic & Reconstr. Surgery	Diran M. Seropian, Ft. Lauderdale	William G. Taylor, Tampa	
Preventive Medicine, Fla. Soc.	Carl Fromhagen Jr., Clearwater	James A. Horton, Okeechobee	
Proctologic Society	Matthew A. Larkin, Miami	Manuel L. Carbonell, Miami	
Psychiatric Society	Alfred D. Koenig, St. Petersburg	Walter M. White Jr., St. P'bg.	
Radiological Society	John C. Jowett, Windermere	Wade Rizk, Jacksonville	
Surgeons, Am. Coll., Fla. Chap.	Emmet F. Ferguson Jr., Jack'ville	Harry W. Reinstine Jr., J'ville	
Surgeons, Gen., Fla. Assn.	Henry J. Babers Jr., Gainesville	Clyde M. Collins, Jacksonville	
Surgeons, Int. Coll., Fla. Chap.	Morris H. Blau, Miami	Wendell J. Newcomb, Pensacola	
Surgeons, Thoracic, Fla. Society	Richard H. Blank, Tampa	Carlos R. Lombardo, Miami	
Urological Society	Miles W. Thomley, Orlando	Horace D. Atkinson, W. Palm Bch.	
Florida			
American Cancer Society, Div.	John J. Fomon, M.D., Miami	Mrs. Peggy Lombardo, J'ville	Ft. Lauderdale, Nov. 8-10, '68
Arthritis Foundation, Chap.	Mr. William Namack III, Sarasota	Miss Barbara White, Gainesville	Orlando, Apr. 5, '69
Basic Science Examining Board	Paul A. Vestal, Ph.D., Winter Park	Theodore A. Ashford, Ph.D., 1832 Bearss Ave., Tampa 33612	Miami, Nov. 2, '68
Blood Banks, Association	Edward S. Cestaric, M.D., Ft. Lauderdale	Mrs. Alma Del Valle, Tampa	Tampa, Apr. 24-26, '69
Blue Shield of Florida, Inc.	Warren W. Quillian, M.D., Coral Gables	Henry J. Babers Jr., M.D., Gainesville	Bal Harbour, May 14-18, '68
Board of Medical Examiners	Carl C. Mendoza, M.D., Jacksonville	J. Champneys Taylor, M.D., 1661 Riverside Ave., Jacksonville	Orlando, Jan. 26-28, '69
Crippled Children & Adults, Soc.	Mr. J. W. WcWhirter Jr., Tampa	Mr. David S. Walker Jr., Miami	Daytona Beach, Nov. 7-9, '68
Diabetes Association	William C. Thomas Jr., M.D., Gainesville	George P. Heffner, M.D., Ft. Lauderdale	Miami Beach, Oct. 1, '68
Heart Association	T. L. Batchelder, M.D., Jack'ville	Nancy Noble, Ph.D., Miami	Ft. Lauderdale, May 30-Jun 1, '69
Mental Health Assn. of Fla., Inc.	Robert H. Vinson, M.D., Vero Bch.	Mrs. Alyce Christ, Cocoa Beach	Jacksonville, Apr. 17-19, '69
Nat'l Multiple Sclerosis Soc.	Mr. Harold W. Comfort, New York	Mr. Robert E. McWeeney, H'wood	
Prevention of Blindness, Soc.	Mr. R. B. Matthews, Coral Gables	Mrs. Richard Nosti, Tampa	Tampa, Nov. 1968
Public Health Association	Mr. J. N. Conger, J'ville	Miss Margaret McLendon, J'ville	Daytona Beach, Oct. 10-12, '6
Retarded Children, Association	Mr. M. P. Smith, Clearwater	Mrs. Howard Lang, Miami	Daytona Beach, May 1969
Thoracic Society	Nelson H. Kraeft, Tallahassee	Richard G. Connar, M.D., Tampa	Miami Beach, May 1969
Tuberculosis & Res. Dis. Assn.	Mr. R. A. Caruthers, Orlando	Mr. C. W. Lantz, Hollywood	Miami Beach, May 1969
United Cerebral Palsy of Florida	Mr. J. P. Hilburn, Tampa	Mr. Harry Botwick, Miami	November 1968
Woman's Auxiliary	Mrs. Linus W. Hewit, Tampa	Mrs. Lloyd K. Netto, W. Palm Bch.	Bal Harbour, May 14-18, '69



when relief
means so much
in keeping
your G.U.
patient comfortable

URISED®

CONAL PHARMACEUTICALS INC

Clinically effective for G.U. Therapy[1-5]

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug"—but a *useful* one.

It fills a need in urologic and general practice—a need for a mild but reliable agent with a very low order of toxicity. It can be used alone to treat mild and uncomplicated urinary infections. It can be used as "interim therapy" while awaiting the results of urine culture. It can be used as an adjunct (to relieve pain and spasm) with almost any other form of antibacterial therapy.

The characteristic blue/green urine tells the patient that something is happening. The patient generally tells *you* that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

URISED®

Each Blue-Coated Tablet contains Active:

Atropine Sulfate	0.03 mg.	Methylene Blue . .	5.4 mg.
Hyoscyamine . .	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine .	40.8 mg.	Benzoic Acid . . .	4.5 mg.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

(*Stocked Nationally Through All Service Wholesale Druggists*)



CONAL
PHARMACEUTICALS, INC
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

ANESTACON™ • CYSTOSPAZ® • MANDACON™ • URISED®
URISEDAMINE® • ŪTRASUL® Tablets and Suspension

Printed in U.S.A.

MAR. 19

Florida Medical advertisers

Abbott Laboratories
- Enduron 778a
- Enduronyl 778a
- Eutron 778a, 779

Anderson Surgical Supply Co. 788

Ayerst Laboratories
- Mediatric 792-793

Breon Laboratories
- Fergon 772

Bristol Laboratories
- Tetrex F 712

Burroughs-Wellcome Co.
- Polysporin 786

Campbell Soups 770a

Coca-Cola 782

Conal Pharmaceuticals
- Urised 794a

Convention Press 788

Dow Chemical Company
- A & I Bioproducts 715

Eaton Laboratories
- Furacin 721

Geigy Pharmaceuticals
- Tandearil 718-719

Highland Hospital, Inc. 782

Hill Crest Hospital 791

Hynson, Westcott & Dunning, Inc.
- Lactinex 707

Lakeland Manor 776

Lakeside Laboratories
- Cantil 714
- Imferon 771
- Norpramin 716-717

Lederle Laboratories
- Achrostatin 720, 772
- Declostatin 709
- Peritinic 730
- Tine Test 787

Eli Lilly & Co.
- Darvon 722
- Trinsicon 714a

Medical Supply Co. 787

National Drug Co.
- Quinamm 730

Parke-Davis & Co.
- Benadryl 714a
- Povan 780-781

P. L. Dodge Memorial Hospital 788

PM of Florida 791

William P. Poythress & Co.
- Trocinate 776

Riker Laboratories
- Norflex 706

A. H. Robins, Inc.
- Robinul Forte 774-775

Roche Laboratories
- NCME 710
- Valium Back Cover

Wm. H. Rorer, Inc.
- Emetrol 720
- Parepectolin 778

St. Francis Hospital 787

Sandoz
- Mellaril 770a

G. D. Searle Co.
- Ovulen-21 770a

Stamas Boats 786a

Strasenburgh Laboratories
- Omni-Tuss 786a

Stuart Co.
- Mylanta 714a

Surgical Supply Co. 788

Tucker Hospital, Inc. 786

Warner Chilcott Laboratories
- Sinutab 730a

LIBRARY
AUG 20 1963
NEW YORK ACADEMY OF MEDICINE

Open-eyed nights





Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern. By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit l

Precaution
convulsants
—particular
action of V
cotics, barbi
Employ usu
with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

ROCHE
Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.

NY ACADEMY MED LIBRARY
2 EAST 103RD ST
NEW YORK NY 10029

M®(diazepam)

...for the relief of psychic tension, alone or with associated depressive symptoms

THE JOURNAL OF THE
BALCONY
Florida Medical ASSOCIATION

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M D

SEPTEMBER, 1968 • VOLUME 55 • NUMBER 9



Is it depression?

She says "I'm always on edge..."



...but her other symptoms: depressed mood, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co. Inc West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

N THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine elaxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

Literature on indications and dosage avail-ble on request.

- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

THE JOURNAL OF THE
Florida Medical ASSOCIATION
SEPTEMBER, 1968 • VOLUME 55 • NUMBER 9

scientific

Capsules on Infectious Diseases 815
LEIGHTON E. CLUFF, M.D.

Conservative Treatment of Trigger Thumb in Infants and Children 819
JAMES J. CONNERS, M.D. AND LEWIS J. OBI, M.D.

Isolated Fingertip Injuries 820
JOHN WESLEY SNOW, M.D.

Psychodynamics of Narcotic Addiction 831
GEORGE W. BARNARD, M.D. AND LINDA RITCH

Pleural Drainage for the Ambulatory Patient 835
ROBERT KEITH FABRIC, M.D.

feature

Florida Regional Medical Program 855
H. PHILLIP HAMPTON, M.D. AND SAMUEL P. MARTIN, M.D.

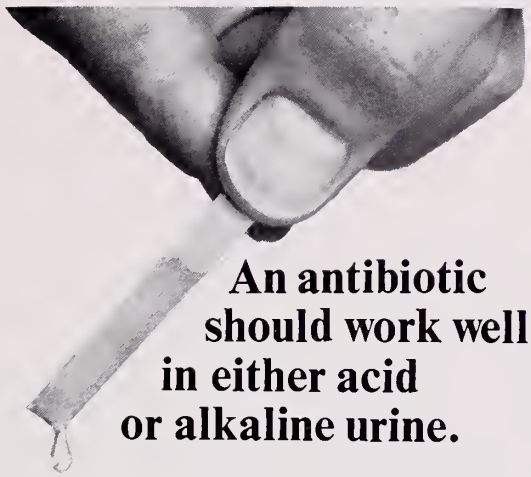
sections

Comment 848
Deaths 869
Editorial 839
Medicolegal 861
President's Page 807

information

Advertisers 875
Classified 872
Florida Medical Association Officers and Council Chairmen 879
Information for Authors 805
Meetings 865

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48

Announcing the blood chemistries anyone in your office can do.

Those using Diagnostest* reagents and instruments. We train your nurs or medical assistant to use this simple, accurate system. For measurin hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and ur acid. You get results in minutes. And the system includes everything yo need. Write today for full information.

*Trademark of The Dow Chemical Com

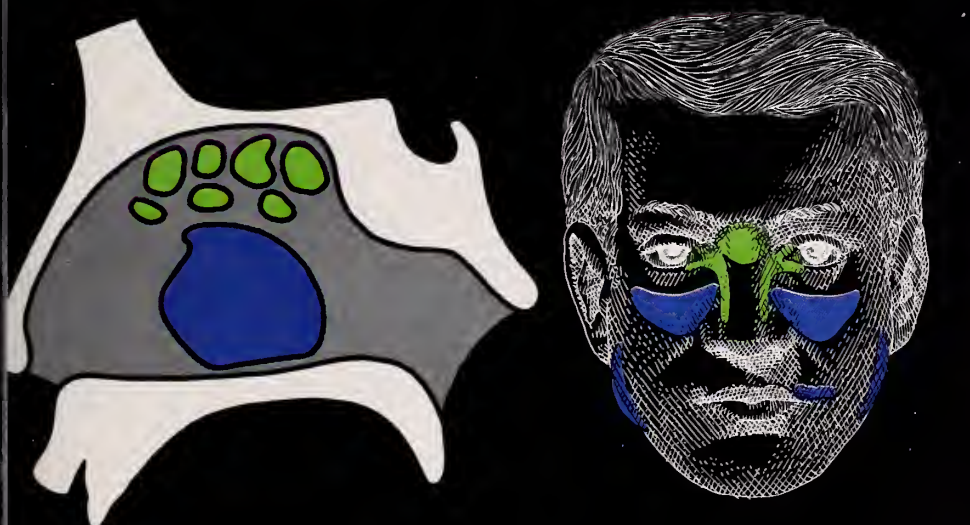
DOW

Sources of sinus headache



REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB



Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q.* 4 *h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA **SINUTAB®** FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

WARNER-CHILCOTT Morris Plains, N.J.



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

ACHROMYCIN® WORKS HERE
TETRACYCLINE



Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number, 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P.O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE Florida Medical ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

OSCAR W. FREEMAN, M.D.
Assistant Editor

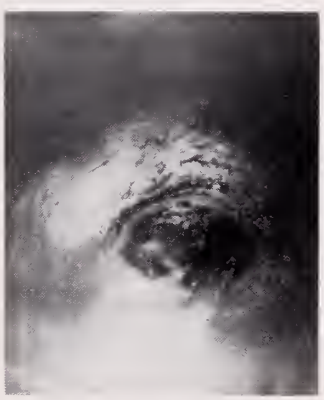
RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

GEORGE H. ROWE JR.
Associate Managing Editor

LOUISE RADER
Assistant Managing Editor



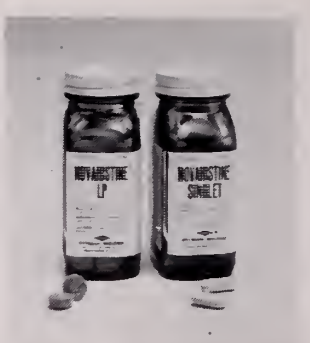
SEPTEMBER COVER

This photograph of the eye of Hurricane Betsy courtesy of the U.S. Air Force and SEA FRONTIERS, magazine of the International Oceanographic Foundation.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



"Nothing else I've tried seems to work, so I decided to give you a crack at it."



Workmen's Compensation Medical Fees

One matter which has been of great concern to your officers, Executive Committee and Board of Governors in the past few months has been our seeming inability to arrive at a proper solution to Workmen's Compensation medical fees. Dr. Robert Zellner and his committee have spent endless hours in conferences, meetings and phone calls with no settlement. At one time, in May, it appeared that a compromise agreeable to the Industrial Commission and to the Florida Medical Association had been finalized. Then suddenly, all negotiations were called off. As of late July, we are presumably no further along than we were many months ago. Your Executive Committee once again is going to attempt to find some answer that will be acceptable to both sides. Our plea is for the membership, especially the orthopedists, to continue to exercise patience and let us continue negotiations for usual, customary and suitable fees. I can assure you that your officers are aware of the problem and are working on it constantly.

One matter that came before the AMA House of Delegates in June was something that was not highly publicized. The delegates, in several resolutions, took a hard look at the public image of the AMA. Several delegations thought this image should be improved. As a result, a new public relations program, proposed by the Board of Trustees and approved by the delegates, includes the hiring of an outside consultant. This consultant already has made several suggestions which should prove helpful.

Dr. Gerald Dorman of New York, AMA's new president-elect, apparently has the background to cope with the AMA's financial problems. He is former secretary-treasurer of the AMA, has been on the AMA Board of Trustees and has been a vice president and medical consultant to the New York Life Insurance Company. He spoke of his concern regarding the recent IRS ruling that the AMA and other professional and technical organizations must pay taxes on profits derived from advertising that appears in their journals. This, of course, also is a problem with our own JOURNAL, although at present we are not showing a profit.

Jack R. Cleveland

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		(Contains 15% alcohol†) †Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound

AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada 6838

pressure
PRESSURE
Sixth Straight Setback
New York Stock Exchange Trading
Drop
DISTRICT COURT
NASSAU COUNTY
Internal Re
VIOLATIC
NO PARKING ZO
RESERVED SPACE
BLOCKING DRIVEW
EMERGENCY DRIVEW
WITHIN 10 FT. OF FIR
PARKING WITHOUT PE
PARKING IN UNASSIGN
PARKING IN LOADING DOCK
WARNING

When life's pressures build up blood pressure

in the hypertensive patient

's pressures and frustrations can often set stage for a rise in blood pressure in the ertensive patient. Emotional fluctuations of od pressure may be especially intensified in hard-driving, aggressive individual who tinuously pushes himself. Along with your ice to help the patient adjust to living with ertension, you can also prescribe help in form of HYDROPRES.

ROPRES, a combination of two proven anti-ertensive agents, has a mild tranquilizing ct that lets the patient relax as it reduces blood pressure. It alleviates symptoms as-ated with hypertension, such as headache tachycardia, that frequently reflect the eral tenseness of the patient.

It's worth noting that potassium loss with HYDROPRES at usual therapeutic doses is usually minimal, and a diet rich in potassium normally avoids serious depletion.

Another point to remember: When other antihypertensive drugs are used adjunctively they must be given at one-half their usual dosage simply because HYDROPRES potentiates the action of such agents. HYDROPRES is contraindicated in anuria and in patients known to be sensitive to hydrochlorothiazide or reserpine.

So, when life's pressures build up blood pressure, consider HYDROPRES to help your hypertensive patient feel more relaxed while under pressure.

HYDROPRES®

ANTIHYPERTENSIVE

HYDROPRES-25:	HYDROPRES-50:
25 mg. hydrochlorothiazide	50 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet	0.125 mg. reserpine per tablet

helps your patient relax as it lowers his blood pressure

For additional prescribing information, please see following page.

INDICATIONS: Mild to severe hypertension.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to hydrochlorothiazide or reserpine. Nursing mothers. Electroshock therapy; discontinue drug at least 7 days before initiating electroshock therapy.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis. Dosage of other antihypertensive drugs, especially ganglion blockers, must be reduced by at least 50 percent because HYDROPRES potentiates their action. A further reduction in dosage or even discontinuation of the other antihypertensive drugs may be necessary as blood pressure falls.

Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery frequently required and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs. The possibility of sensitivity reactions should be considered in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives (including thiazides) and reserpine. Nasal congestion, lethargy, depressed Moro reflex, and bradycardia may appear in infants born of reserpine-treated mothers. Thiazides cross placenta and appear in cord blood. In women of child-bearing age, potential benefits must be weighed against possible hazards to fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS AND SIDE EFFECTS: Hydrochlorothiazide: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive, or patient is receiving parenteral fluids or medication such as digitalis. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant steroid or ACTH therapy, or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypochloremic alkalosis occurs infrequently and is rarely severe. If dietary salt is unduly restricted, especially during hot weather, in severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. Insulin requirements in diabetics may be altered. May produce hyperglycemia and glycosuria in latent diabetics. Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, jaundice. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have associated thiazides with pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. Whenever adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn. **Reserpine:** Reactions most often reported include excessive sedation, nightmares, nasal congestion, conjunctival injection, enhanced susceptibility to colds, muscular aches, headache, dizziness, dyspnea, anorexia, nausea, increased intestinal motility, diarrhea, weight gain, dryness of mouth, blurred vision, flushing of skin, and pruritus. Skin rash, dysuria, syncope, nonpuerperal lactation, impotence or decreased libido, angina pectoris, other direct cardiac effects (e.g., premature ventricular contractions, fluid

helps your patient relax as it lowers his blood pressure



retention, congestive failure), and CNS (including occ
sensitization have been noted. Use cautiously in hyperten
patients with coexistent coronary artery disease to avoid
cipitous drop in blood pressure. Since reserpine may incre
gastric secretion and motility it should be used cautiousl
patients with history of peptic ulcer, ulcerative colitis, or o
gastrointestinal disorders. May precipitate biliary colic in
tients with gallstones, or bronchial asthma in suscep
patients. May cause hypotension, including orthostatic h
tension. Since significant hypotension and bradycardia
develop during anesthesia, discontinue two weeks prio
surgery. A Parkinson's disease-like syndrome, usually rev
ible with decreased dosage or discontinuance of therapy,
been observed. Anxiety, depression, or psychosis may deve
Pre-existing depression may be aggravated.

Before prescribing or administering, read product circular package or available on request.

HYDROPRES
ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES
50 mg. hydrochlorothia
0.125 mg. reserpine per t

MERCK SHARP & DOHME | **where today's theory is tomorrow's thera**
Division of Merck & Co., Inc., West Point, Pa. 19486



This isn't the end of the line.

(New TUBEX® are constantly being added)



Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX®

Wyeth

UNIT DOSE MEDICATION

sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

Design for an ear anti-infective

esigned to act promptly gainst bacterial athogens and pain

titis media (when the tympanic membrane is perforated) and otitis externa both spond to the bactericidal action of racin® (nitrofurazone) in Furacin-HC itrofurazone-hydrocortisone) Otic. Its oad antibacterial spectrum includes ost of the organisms encountered in rface infections (but only certain strains Pseudomonas). The hydrocortisone mponent in Furacin-HC Otic affords pid relief of painful swelling.

esigned to let the ear rain freely

ne water-soluble base of Furacin-HC tic permits free drainage and provides hygroscopic vehicle.

esigned to please and rotect the patient

opical Furacin-HC Otic lets you reserve stemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Alsa available: Furacin® Otic (nitrofurazone with nifuroxime and diperodon HCl). The wide antibacterial range of Furacin is augmented by the antimycotic activity of Micafur® (nifuroxime). Diperodon hydrachlaride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacterial otitis externa, otomycosis or bacterial otitis media (when the eardrum is perforated).

Precautians: Sensitization to nitrofurazane may occur with prolanged use and is mare likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Cantraindicatians: The usual contraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesions of skin or ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Farmula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrofurazone, and 1.0% hydrocortisane acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrofurazone, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrachloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

™Originators and Developers of The Nitrofurons
EATON LABORATORIES
Division of The Norwich Phormocol Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone/hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl





Now...twice as much as before in each teaspoon

400,000 units of potassium penicillin V per teaspoonful

New...V-Cillin K®, Pediatric, 250 mg.

Potassium Phenoxymethyl Penicillin

Lilly

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

800192

Florida Medical | scientific

Capsules on Infectious Diseases

Leighton E. Cluff, M.D.

Questions asked of me by physicians attending lectures or symposia in which I have participated serve as the basis for this paper. Over many years I have observed that such questions often lead to useful and practical answers and opinions. Textual material has the advantage of explanation, background and cautiously considered statements, all of which help to avoid misunderstanding and misinterpretation. Nevertheless, most of us carry away from a paper or lecture capsules of useful information and not the detail. For this reason I have boldly attempted to select some questions asked and provide brief categorical answers. It is hoped these capsules will prove informative and useful. Disagreements will arise over any categorical statement and amplification may be required. I will be happy to attempt to provide amplification upon direct query.

What is the treatment of choice for hemolytic (group A) streptococcal infection?

Streptococcal pharyngitis and other group A streptococcal infections should be treated with penicillin unless the affected individual is allergic to this antibiotic. Erythromycin is a suitable substitute in such persons. Treatment should be continued for ten days, even though the infected patient clinically is well. Earlier termination of therapy will not reliably prevent the development of rheumatic fever. Sulfonamides never should be used to treat group A streptococcal infection as such therapy will not prevent rheumatic fever, although it will terminate the pharyngitis. Sulfonamides, however, are effective as long-term prophylaxis to prevent recurrent streptococcal infection and rheumatic fever.

Is it possible to distinguish exudative pharyngitis due to streptococci and viruses?

Pharyngitis due to some viral respiratory infections occasionally is difficult to differentiate from streptococcal pharyngitis. The latter infection, however, is uncommonly associated with rhinitis, laryngitis or cough, but is characterized by sudden onset, high fever (except in children) and leukocytosis. Throat culture taken before initiating treatment will provide a guide for beginning, continuing or discontinuing penicillin therapy after 24 hours.

Should antibiotics be used in treatment of viral respiratory illness?

Antibiotic treatment of viral respiratory disease will not shorten the duration of this illness and will not reliably prevent bacterial superinfections. Such treatment may actually increase the risk of superinfection, particularly by antibiotic resistant microorganisms.

Dr. Cluff is professor and chairman, Department of Medicine, University of Florida College of Medicine, Gainesville.

Are antibiotics of any value in treatment of acute (not acute recurrent) sinusitis?

Acute sinusitis usually is attributable to pneumococci, group A streptococci or staphylococci. The duration of symptoms can be shortened by treatment with erythromycin for five days, particularly when accompanied by methods to accelerate drainage of the involved sinuses.

Patients occasionally may develop metastatic infection after manipulation or incision and drainage of a staphylococcal abscess. What can be done to prevent this?

Patients with boils or other abscesses due to staphylococci and managed by incision and drainage should be given an antistaphylococcal antibiotic immediately prior to and for 24 hours after manipulation of the lesion to control bacteremia and prevent metastasis of the infection. Oxacillin, cloxacillin, cephalothin or erythromycin should be used if it is not certain whether or not the staphylococcus is resistant to penicillin.

Septic thrombophlebitis is a serious complication of the use of plastic intravenous catheters. What should be done to prevent this?

Intravenous plastic catheters should be inserted with strict aseptic technique. The site of skin penetration should be covered with a sterile occlusive dressing and the catheter should be left in place no longer than two days, except under extenuating circumstances, to prevent development of septic thrombophlebitis.

How much penicillin is necessary to treat pneumococcal pneumonia, and how long should treatment be continued?

Pneumococcal pneumonia, usually characterized by sudden onset with a *single* chill, pleuritic pain and rusty sputum and occurring predominantly in alcoholics and patients with underlying cardiopulmonary disease, should be treated parenterally with 600,000 units of penicillin G each 24 hours until the patient is afebrile for at least two days. There is no convincing evidence that additional penicillin is more effective unless infectious complications such as pyoarthritis, empyema or meningitis are present.

Is the gram stain of sputum valuable in diagnosis of pneumonia?

Gram stain of sputum from the patient with pneumonia is a useful guide to antibiotic treatment. If only gram positive cocci are seen, pneumococcal pneumonia and penicillin treatment are indicated in most instances. If many gram negative bacilli are seen, klebsiella or hemophilus pneumonia are possible and cephalothin, ampicillin, colimycin, chloramphenicol plus streptomycin or tetracycline may be indicated. Cultural confirmation is required for rational continuing treatment. Hemophilus pneumonia is uncommon in adults except during epidemics of influenza. Staphylococcal pneumonia almost invariably is associated with lung cavitation and bacteremia with multiple chills.

Fever occasionally recurs several days after beginning treatment of pneumococcal pneumonia. Is this due to superinfection?

Recurrence of fever after defervescence in patients with uncomplicated pneumococcal pneumonia treated with penicillin is most often due to drug fever.

What should be done for the patient who converts from negative to positive tuberculin test?

Conversion from negative to positive tuberculin test is a sound indication for treatment of the patient with INH for 12 months to prevent active progressive disease in near or distant future.

Should patients with atypical mycobacterial lung disease be isolated?

Atypical mycobacterial infection of the lung is not known to be transmissible from person to person and requires less attention to control of contagion than does tuberculosis.

When should patients with influenza be hospitalized?

Patients with acute influenza should not be hospitalized unless accompanied by complications. Staphylococcal pneumonia in these patients when hospitalized is too common and has a high mortality rate.

Antibiotic treatment of "viral" infections is said to be of no value. What should be done with the patient thought to have viral pneumonia?

Patients with presumed "viral" or primary atypical pneumonia should be treated with tetracycline. It is not possible to clinically differentiate mycoplasma pneumonia from viral pneumonia under most circumstances, and mycoplasma pneumonia responds well to tetracycline. Recent

studies suggest that many instances of "viral" pneumonia are due to mycoplasma. A positive cold agglutinin test in convalescence helps suggest the patient had mycoplasma pneumonia.

When an air fluid level develops in a lung abscess is this indicative of inadequate antibiotic treatment?

An air fluid level in a lung abscess is an indication of inadequate drainage requiring bronchoscopy or other measures to insure drainage. This is more important than the antibiotic therapy selected.

Prior to bacterial cultural information what can be done to determine if diarrheal disease is due to enteric bacterial pathogens, viruses or parasites?

Stool examination for pus cells, blood and parasites is useful in differentiating viral from bacterial and parasitic diarrheal disease. Pus cells are infrequent in viral or parasitic intestinal disease, whereas lymphocytes or macrophages, respectively, often are found.

Does bowel preparation with neomycin prevent postoperative wound infection?

Bowel preparation with neomycin for abdominal surgery, with or without sulfonamides, has no effect on the frequency of postoperative staphylococcal wound infection but may predispose to infection with neomycin resistant bacteria.

What can be done to prevent urinary tract infections in hospitalized patients?

Over 80% of instances of urinary tract infection and gram negative bacillemia in hospitalized patients are attributable to urethral or bladder catheterization. Catheters, when used, should be inserted with aseptic technique. If an indwelling catheter is employed, a closed sterile drainage system must be used. Periodic irrigation of the bladder with acetic acid solution or with a mixture of polymyxin-neomycin may be useful in preventing bacteremia. Application of an antibacterial ointment to the urethral meatus may limit the occurrence of ascending urinary tract infection about a catheter.

What should be considered in a patient with a urinary tract infection who continues to have fever over several days in spite of antibiotic treatment?

Most instances of acute urinary tract infection are self limited. If fever persists, suspect obstruction of the urinary tract. Relief of the obstruction is essential to eradicate the infection.

What advice should be given to mothers to help control urinary tract infection in their female children?

It is possible that wiping from back-forward by young girls and women following defecation may be an important factor predisposing these persons to urinary tract infection and should be avoided.

What is the treatment of choice in meningococcal disease?

Meningococcal meningitis always should be treated with parenteral penicillin G in doses of 12 to 20 million units a day. Many meningococci are now resistant to sulfonamides.

Occasionally great efforts are made to give prophylaxis to hospital personnel when a patient is admitted with meningococcal disease. Is this necessary?

Prophylaxis of persons in contact with a case of meningococcal disease is unnecessary unless used on a mass scale where there is an epidemic or in intimate family members. Penicillin and sulfonamides should be used prophylactically under these circumstances.

Is it ever unwise to give a bactericidal and a bacteriostatic antibiotic together?

Penicillin never should be given with a bacteriostatic antibiotic such as tetracycline in treatment of bacterial meningitis as these drugs under this condition are antagonistic.

What should be done when it is difficult to be certain of the diagnosis of viral aseptic or tuberculosis meningitis?

Aseptic "viral" meningitis may be associated with reduced spinal fluid glucose content and therefore can be confused with tuberculosis. Patients with aseptic meningitis, however, are usually well within seven days and treatment of tuberculosis meningitis may be deferred for a day or

two for clarification, unless the patient is critically ill or diagnosis of tuberculosis is certain.

Should steroids be used in treatment of septic shock?

Corticosteroids should be given to the patient with septic shock in dosage of 20 mg. hydrocortisone (or equivalent) per kilogram of body weight each 24 hours. Such treatment ordinarily will not be required for more than two to three days. After that time the septic shock will have been contolled or the patient will have expired. The corticosteroid can then be stopped abruptly if continued treatment is not required.

What antibiotics should be given to the patient suspected of having septic shock?

The most important therapy in septic shock in prevention of death is administration of antimicrobial drugs effective against the infecting microorganism. Most cases of septic shock are now attributable to gram negative enteric bacilli, including E. coli, proteus, klebsiella and pseudomonas. Most of these arise from infection of the urinary tract and information about the bacteria in the urine can guide selection of antibiotics for treatment of sepsis. If the infecting organism is unknown we recommend treating the patient with cephalothin (4 gm. per day), colimycin IM or polymyxin IV (300 mg. per day) and kanamycin (1.5 gm. per day). This combination will be effective against most of the bacteria causing septic shock and treatment can be made more specific when bacteriological data is available. If renal failure is present or develops, the dosage of the colimycin and kanamycin should be correspondingly reduced. Except under extraordinary circumstances, the total dose of kanamycin should not exceed 12 to 15 gm., as the frequency of toxic deafness increases above this dose. Colimycin may cause some elevation of blood urea nitrogen which usually is reversible and controlled by reduction in dosage.

What antibiotics should be given to the patient with serious staphylococcal infection?

Serious staphylococcal infections should be treated with a penicillinase resistant penicillin drug (oxacillin, cloxacillin, nafcillin, methicillin, cephalothin) until sensitivity of the organism to penicillin is determined. If sensitive to penicillin, substitution with penicillin G alone is preferable. Other antibiotics such as erythromycin should not be used in treating serious staphylococcal disease where drug administration must be prolonged, as resistance to the drug will be acquired by the microorganism after seven days in most instances. This rarely, if ever, happens during treatment with penicillin or its analogues.

▶ Dr. Cluff, University of Florida College of Medicine, Gainesville 32601.

Conservative Treatment of Trigger Thumb In Infants and Children

James J. Conners, M.D. and Lewis J. Obi, M.D.

The presently accepted treatment for trigger thumb is excision of the pulley. We would like to present three cases in which the condition has been relieved and which we have followed conservatively for an average time of four and one half years. As such, there is no major objection to an operation other than the normal hazards which accompany operating upon children; however, we believe that surgery is not indicated until the child has been followed for a period of time.

A review of the literature disclosed 32 cases reported by eight investigators during the past 25 years. All patients were surgically treated.[1-6] The occasional reports advising conservative treatment[3,31] have involved patients followed for a short time only; surgical treatment was the usual result. We have nothing to add to previous reports regarding trigger thumb etiology.[1,3,6]

Report of Cases

Case 1. — A 3½-year-old boy was first seen at age 14 months. Shortly prior to being seen, the mother had noted that the child held his left thumb in flexion at the interphalangeal joint; it could be extended only by using external force. This did not appear to be painful to the child and there was no history of injury. Examination revealed thickening on the volar side of the first metatarsophalangeal joint. On motion of the interphalangeal joint, a movable mass could be felt at the metatarsophalangeal joint. The thumb was held in flexion and would lock. External force was needed to extend the distal phalanx. X-rays of the hand were normal. A glove cast was applied with the thumb held in extension for a period of two weeks. Following removal of the plaster, the child was not seen again for 18 months, at which time he was having only occasional snapping of the thumb. Three years later the child was not having symptoms but could lock the thumb with force. It had never locked involuntarily and, according to the parents, it no longer presented a problem.

Case 2. — This child was first seen at the age of two years. Three weeks prior to this time the parents had noted a flexion deformity of the left thumb. There was no definite history of injury. The initial examination revealed thickening on the volar side of the first metatarsophalangeal joint. A movable mass was felt in the area of thickening on motion of the distal phalanx. The thumb would lock in marked flexion and could be released only by applying some external force. This condition was present bilaterally. X-rays were normal. Casts were applied with the thumbs in extension on both sides for a period of 18 days. Following this, we used a soft dressing for approximately two weeks. There was occasional snapping for several weeks after all immobilization was discontinued. This child was seen six years after the initial visit and has not had any snapping or symptoms since several weeks after the conclusion of the immobilization.

Case 3. — A 2-year-old white boy was first seen with bilateral trigger thumbs. This had not been symptomatic and the parents noted the condition only a few weeks prior to his first examination. The examination again revealed thickening on the volar side of the MP joint. The typical locking phenomenon was present and external force was necessary to extend the distal phalanx. A movable mass was detected at the volar side of the metatarsophalangeal joint on motion of the interphalangeal joint. Treatment consisted only of observation. This child was seen one month later at which time the deformity was still present but was not occurring as frequently. This child was not seen again until ten months later at which time there were no symptoms or locking. Examination revealed only minimal thickening in the region of the volar side of the metatarsophalangeal joint. The locking phenomenon could not be reproduced.

Summary

Three cases of trigger thumb successfully treated conservatively, with long term follow-up, are presented. Follow-up has been sufficiently long to warrant the use of closed treatment prior to advising surgery.

References

1. Zadek, I.: Stenosing Tenovaginitis of Thumb in Infants, J. Bone & Joint Surg. 24:326-328 (Apr.) 1942.
2. White, J. W., and Jensen, W. E.: Trigger Thumb in Infants, Am. J. Dis. Child. Pp. 141-145, 1946.
3. Sprecher, E. E.: Trigger Thumb in Infants, J. Bone & Joint Surg. Vol. 31-A, 1949.
4. Hodgins, T. E., and Lipscomb, P. R.: Bilateral Trigger Fingers in a Child: Report of Case; Staff Meetings of the Mayo Clinic, Vol. 31, No. 9 (May 2) 1956.
5. Pilaszanovich, I., and Halmos, L.: On Stenosing Tenosynovitis in Children, Gyermekgyogyaszat 11:349-352 (Nov.) 1960.
6. Sponsel, H. H.: Stenosing Tenosynovitis of Thumb in Children, Minnesota M. J. 47:399-400 (Apr.) 1964.

▶ Dr. Conners, 1824 King Street, Jacksonville 32204.

Isolated Fingertip Injuries

John Wesley Snow, M.D.

Fingertips are the most frequently injured component of the hand and proper initial management will insure minimum future disability. All injuries of the finger tips can be classified in one of six categories or combination thereof (Fig. 1):

1. Lacerations
2. Amputations
3. Burns
4. Crushes
5. Avulsions
6. Fractures

Lacerations

Fingertip lacerations present the least difficulty in management. If they are stellate and comminuted, small irregular fragments should be debrided and the wound closed without tension (Fig. 2).

If the nail is lacerated it should be preserved and reapproximated by suture, as this gives anatomic realignment and stability. Postoperative rest and elevation will assure painless primary healing.



Fig. 1. — Illustration of various fingertip injuries; the object of treatment is centered around the return of normal hand function.

Severed Tendons

If a distal laceration severs the extensor or flexor tendon it should be reapproximated acutely with #36 stainless steel wire. Slightly overlapping the proximal to the distal ends of the extensor tendon produces a firmer union. The flexor tendon should be joined end-to-end with a Bunnel type permanent stitch. The distal stump may be shortened 1 cm. to prevent the juncture from encroaching upon the superficialis tendon. The tendon sheath should be removed over the excursion of the juncture to prevent adherence and limitation of motion.

Occasionally the flexor or extensor tendon insertion will be avulsed secondary to sudden stress. The classical baseball or mallet finger exemplifies this, as the insertion of the extensor mechanism is avulsed from the base of the distal phalanx.

The earlier closed treatment is begun, the more favorable the results.[1] Injuries operated upon after seven or eight days reveal a fibrous agglutinum surrounding the retracted extensor tendon end. It is held in this gelatinous early scar material and does not move regardless of what passive manipulative procedures are performed. Active extension following closed treatment begun at this point is probably due to scarring between the end of the extensor tendon and Landsmeer's ligaments (Fig. 3). Landsmeer's ligaments themselves probably shorten during closed treatment thereby increasing their effect on the distal interphalangeal joint.

The direct surgical approach to mallet fingers has been unrewarding. The right-angled incision commonly used heals poorly. The extensor tendon shortens rather promptly and even when it will reach the distal phalanx it is difficult to reattach. A lazy S-shaped incision over the distal interphalangeal joint heals satisfactorily if not widely undermined (Fig. 4). Two basal cortical perforations in the distal phalanx will allow passage of a wire suture to anchor the extensor tendon end to the distal phalanx. If when freed the extensor tendon will not reach the distal phalanx, a strip of lateral band may be incised and used as a tendon graft (Fig. 5). The strip is left attached distally and threaded through the basal cortical perforations in the terminal phalanx, recrosses the distal interphalangeal joint and is sutured to the extensor mechanism. A transarticular K-wire and cast will assure immobilization for three weeks after which they are removed and active-passive motion begun. This type graft has been used on the last two mallet fingers with complete return of function[7] (Fig. 6).

Long standing lack of distal interphalangeal joint flexion secondary to a severed profundus tendon which cannot be reapproximated may be repaired in one of several ways. In a supple hand requiring intricate work, a thread-through tendon graft should be performed, leaving the superficialis tendon intact. In a manual laborer with a heavy, battered, stiff hand a tenodesis or fusion of the



Fig. 2. — (a) Comminuted laceration of thumb of 70-year-old white man. (b) Note arborization of digital nerves. (c) Conservative debridement and partial primary closure. A small split-thickness graft was applied in order to close the wound without undue tension.

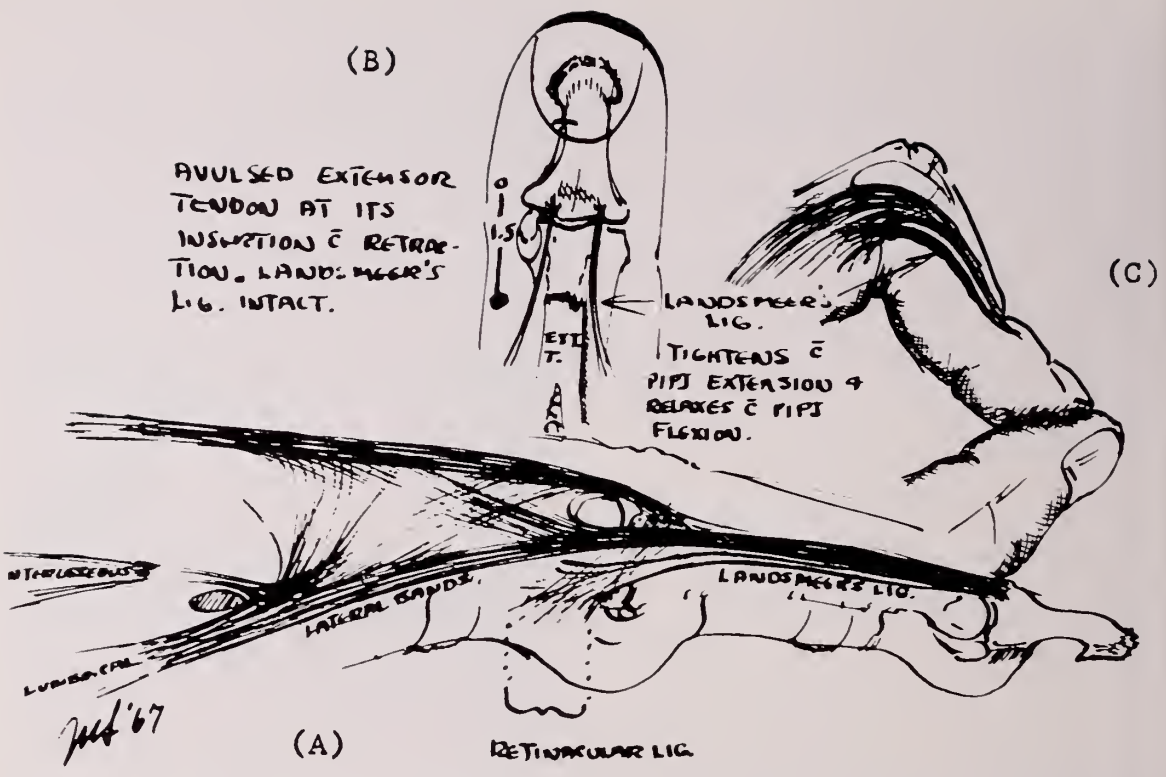


Fig. 3. — (a) Extensor mechanism of finger and its relationship to Landsmeer's ligament. (b) Relationship of Landsmeer's ligament to avulsed insertion of extensor tendon. (c) Classic position for treating mallet finger demonstrating relaxed position of Landsmeer's ligament.

distal interphalangeal joint at 30 degrees of flexion is indicated. When active flexion is present at the proximal interphalangeal joint, flexion at the distal interphalangeal joint can be produced by a tenodesis as demonstrated in Figure 7. This has been done successfully with one patient and will be repeated at a later date.

Nerves

If digital nerves are severed at the time of tendon or other injuries requiring major surgical repair, they should be reapproximated acutely. In an isolated nerve injury it is better to accurately reapproximate the skin and do the nerve juncture as a secondary procedure if necessary.[2] Accurate skin approximation will sometimes realign the nerve ends satisfactorily thus producing reinnervation (Fig. 9). If not, secondary nerve juncture can be performed under sterile conditions where the extent of proximal and distal nerve injury is more easily determined, incisions are elective and the thickened neurilemma is more easily sutured.

When the digital nerve is unsalvagable on the radial border of the index or ulnar half of the thumb with normal sensibility on the opposite side, a neurovascular flap can be switched from the normal side of the involved digit as shown by Littler.[3]

Amputations

Fingertip amputations are common and challenging. Skin loss of less than 1.5 cm. in diameter over the tip without bone or tendon being exposed will heal satisfactorily by secondary intent. The contracting scar will pull the remaining normal skin distally as the size of the wound is decreased. If the skin loss is more than 1.5 cm. in diameter, a split-thickness graft is indicated and its subsequent 30% to 40% contracture also decreases the wound area (Fig. 11).

If the amputation is through the distal phalanx leaving the bone or tendon exposed, several methods of treatment are available. They all consist of coverage with a flap of skin and subcutaneous tissue. A graft over exposed bone produces a painful and unstable tip and is not satisfactory.[4] The thick, white, soft, elastic skin of the abdomen, with its abundant subcutaneous fat, produces bulky and unsatisfactory coverage.

The basic methods for treating fingertip amputation with bone exposed are shown in Figure 10.



Fig. 4. — Eight days postoperatively—blunt trauma with immediate inability to extend finger tip. (b) Extensor tendon found to be severed. Proximal and distal tendon ends freed from encompassing scar. (c) Vertical mattress sutures inserted. Note K-wire fixation proximal interphalangeal joint in 50 degrees flexion with distal interphalangeal joint in extension. (d) Tendon ends reapproximated.

Shortening the remaining bone until primary closure can be performed is the commonly used technique. This assures rapid return to work and is often the treatment of choice in the long, ring and little fingers. Length is vital in the index finger and thumb, and shortening should be avoided. One should remember that a 1 cm. shortening of bony support beneath the nail can make the difference postoperatively between a normal nail and a bird's claw deformity. The proximal 0.5 cm. of the nail needs support from underlying bone plus subcutaneous tissue and skin if a normal nail subsequently is going to develop. If the remaining nail support is less than 0.5 cm., it is best to remove completely the nail germinal center and culde-sac.

The V-Y advancement flap (Kutler Technique) appears to be a sound procedure when adequate marginal skin and subcutaneous tissue remains.[5] In volar oblique amputations adequate tissue is not available.

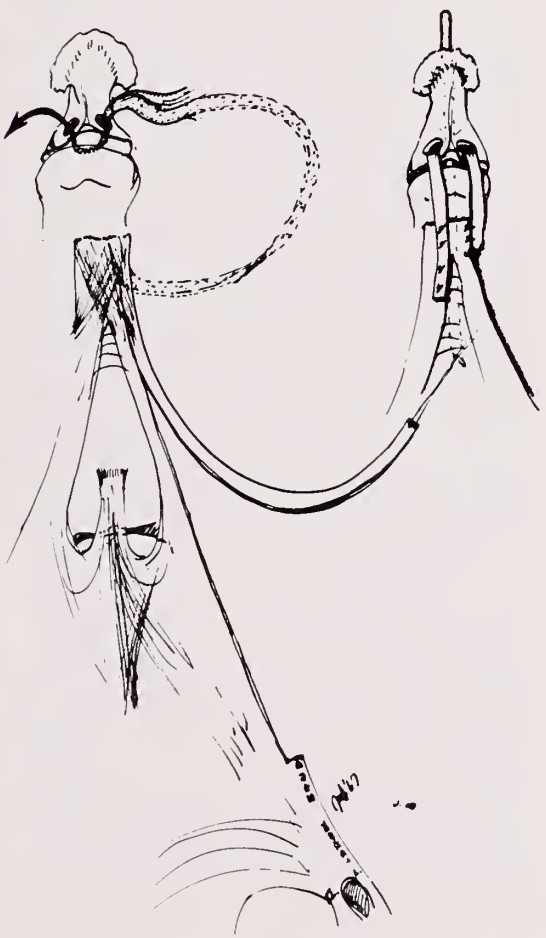


Fig. 5. — Strip of lateral band elevated and threaded through two basal cortical perforations in the distal phalanx to reestablish continuity of the extensor mechanism.

A cross-finger flap is a versatile technique which produces a painless and stable tip with good contour (Fig. 11). Protective sensibility returns to the recipient site and usually is adequate except over the critical area of pinch between the index finger and thumb. Pertinent points in doing a cross-finger flap are:

1. Elevate the flap from neutral zone to neutral zone so that subsequent scar contracture will not limit flexion or extension of the donor finger.
2. Take care when beginning elevation of the flap not to get beneath the lateral bands.
3. Elevate the flap in the fine areolar plane overlying the extensor tendons. The dorsal veins must be severed, cauterized and elevated with the flap. This assures the adequacy of venous return and flap viability. A split-thickness graft should be applied to the donor site before insetting the flap onto the injured finger. The graft should extend well up onto the pedicle so that

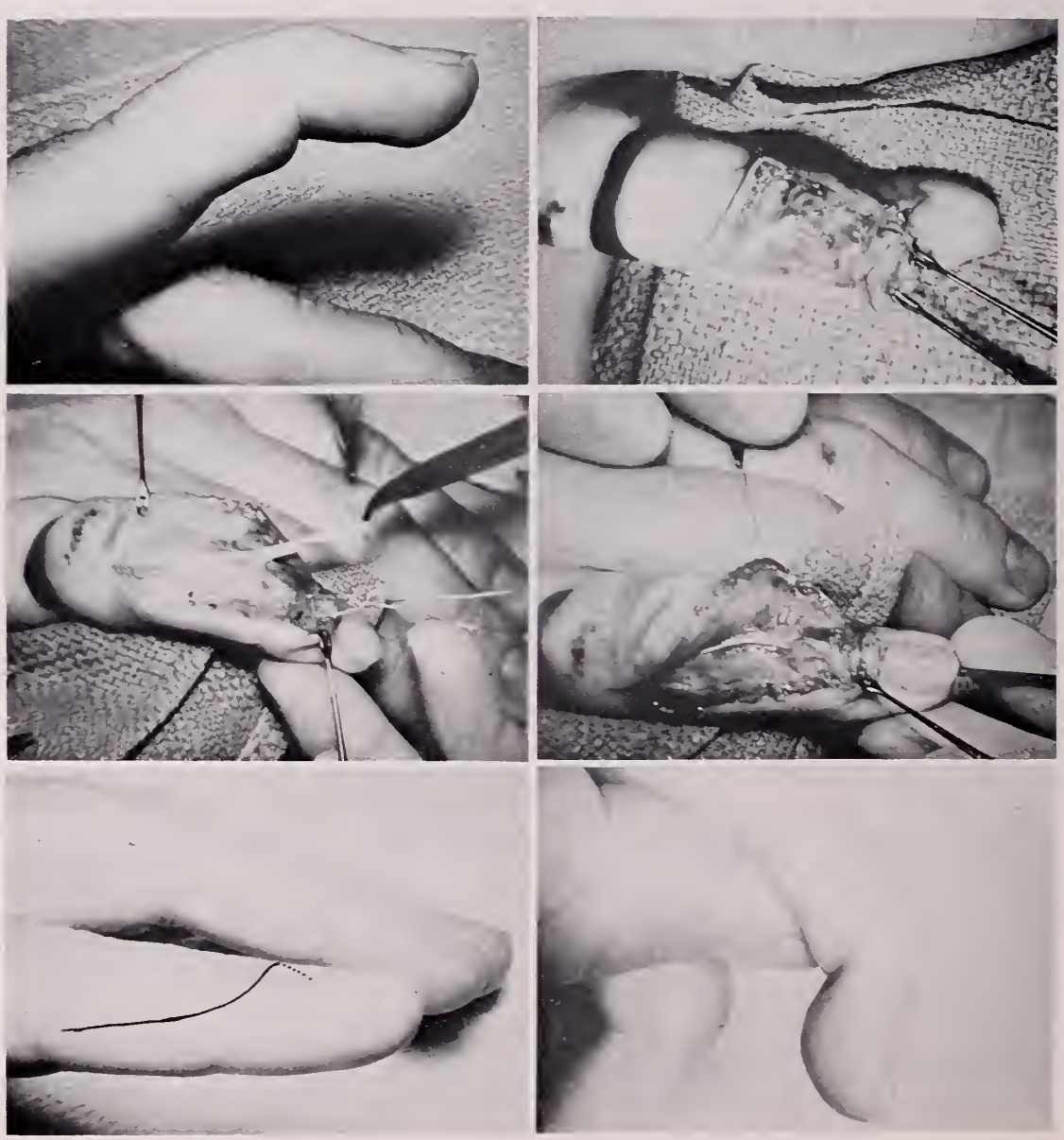


Fig. 6. — From top left (a) Mallet finger of two weeks' duration. (b) Needle through basal cortical perforations of distal phalanx. (c) Elevation of strip of lateral band. Note the wire sutures through the basal cortical perforations. (d) Lateral band threaded through to reestablish extensor mechanism. Note K-wire fixation to distal interphalangeal joint at 180 degrees. (e) Postoperative return of normal function. Note lazy S-shaped incision with avoidance of any right angle flap. (f) Complete return of function.

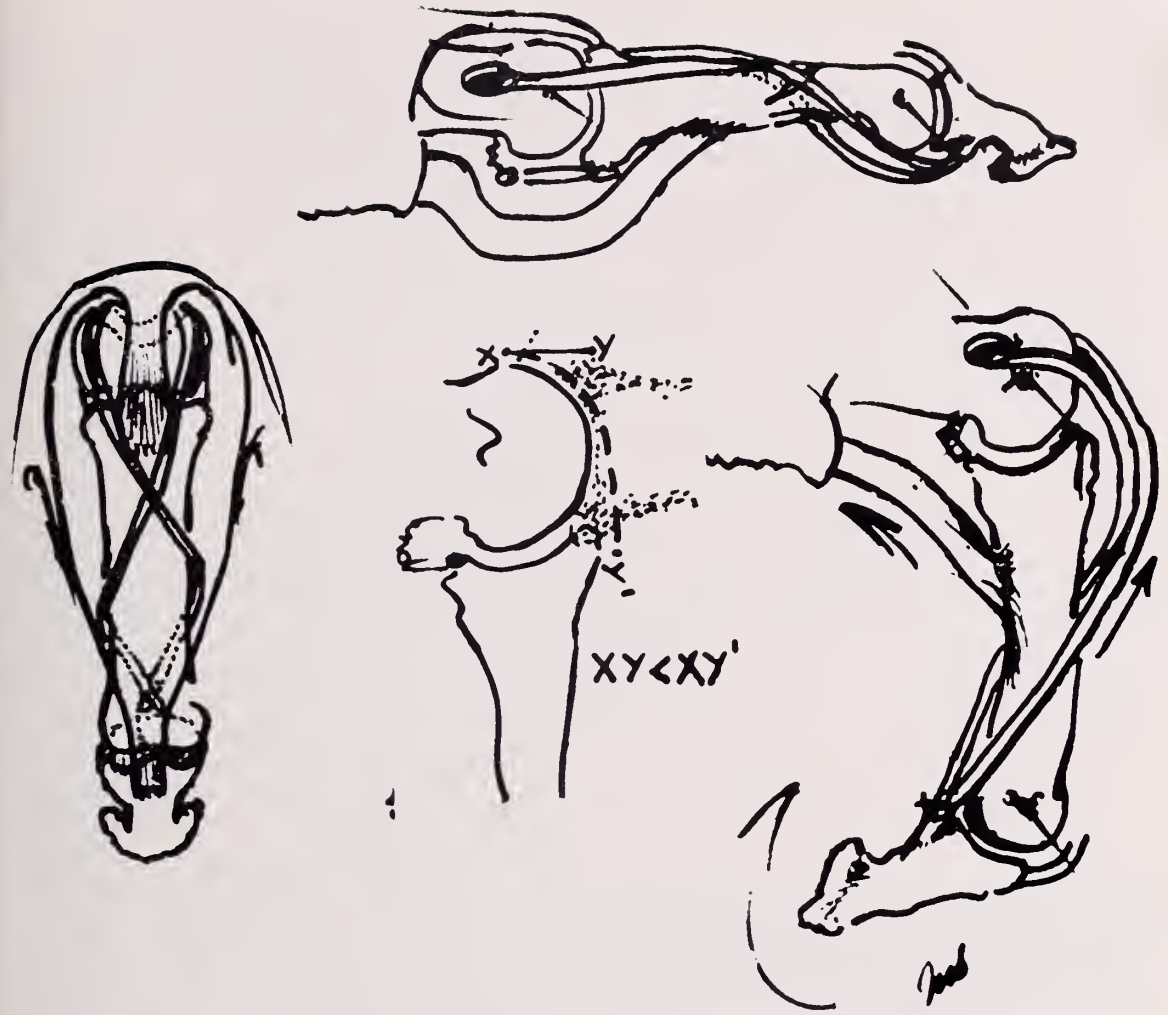


Fig. 7. — Theoretical position of tendon graft to produce flexion of distal interphalangeal joint by a tenodesis effect when active flexion of the proximal interphalangeal joint is present.

the entire wound is closed and remains dry.

4. Leave the pedicle in place for three weeks, detach and inset. Excise the flap from the donor finger in the neutral zone and discard redundant skin.

The thenar flap technique is similar to that of the cross-finger flap, although it requires more interphalangeal joint flexion and therefore produces more postoperative difficulty in limbering up these joints.

A volar flap may be elevated after making an incision along the ulnar and radial neutral border of the involved finger or thumb. The flap contains the neurovascular bundles and usually is elevated to 1 cm. proximal to the proximal interphalangeal joint. Slight flexion of the interphalangeal joints then shortens the length of the finger and permits the volar flap to be sutured over the exposed distal aspect of the terminal phalanx. The incisions in the neutral zones are then closed and the finger left in slight flexion for three weeks after which graduated active-passive motion is begun until full extension occurs. This technique does not require shortening of the remaining bone and results in normal sensibility over the fingertip. It is perhaps the treatment of choice with injuries in the critical area of pinch in the index finger or thumb and in amputations in general in children[6] (Figs. 12 and 13).

Amputations of the index finger proximal to or through the proximal interphalangeal joint are best treated by transmetacarpal amputation either acutely or secondarily (Fig. 14). The first dorsal interosseous should be detached and reinserted on the lateral aspect of the extensor hood of the long finger. This improves strength and contour of the web space. An index finger no longer than the

proximal interphalangeal joint is bypassed in normal hand function.

Burns

With normal sensibility, isolated full thickness burns of the fingertips are unusual. They occur secondary to flame, hot viscous fluids and electrical currents. Full thickness skin loss on the volar aspect is rare due to the very thick corium layer which is present. Injuries sustained in association with large area body burns are not within the scope of this paper.

Fingertip burns should be treated conservatively with a Furacin* dressing and elevation for five or six days. Debridement should then be performed and if no bone or tendon is exposed, the wound closed with a split-thickness graft. On the dorsum, the areolar layer overlying the extensor tendons offers a good plane for debridement. After healing, and depending on the location and finger involved, further treatment may be carried out if needed. Exposed bone or tendon necessitate flap coverage.

*Furacin (nitrofurazone), Eaton Laboratories

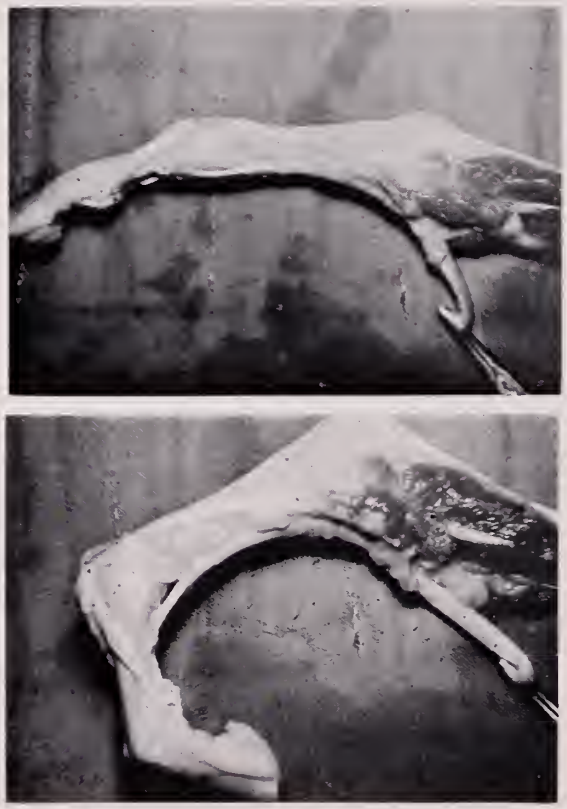


Fig. 8. — Anatomic specimen demonstrating tenodesis effect.



Fig. 9. — (a and b) Mower injury with severance of tendons, nerves and metacarpals of ring, long and index fingers. Blood supply through deep branch of radial artery. Bony architecture reestablished by crossed and intramedullary K-wires; skin debrided and closed. Protective sensibility returned to fingers after primary wound healing. (c and d) Nine months postoperatively —reestablishment of extensor and flexor tendon continuity.

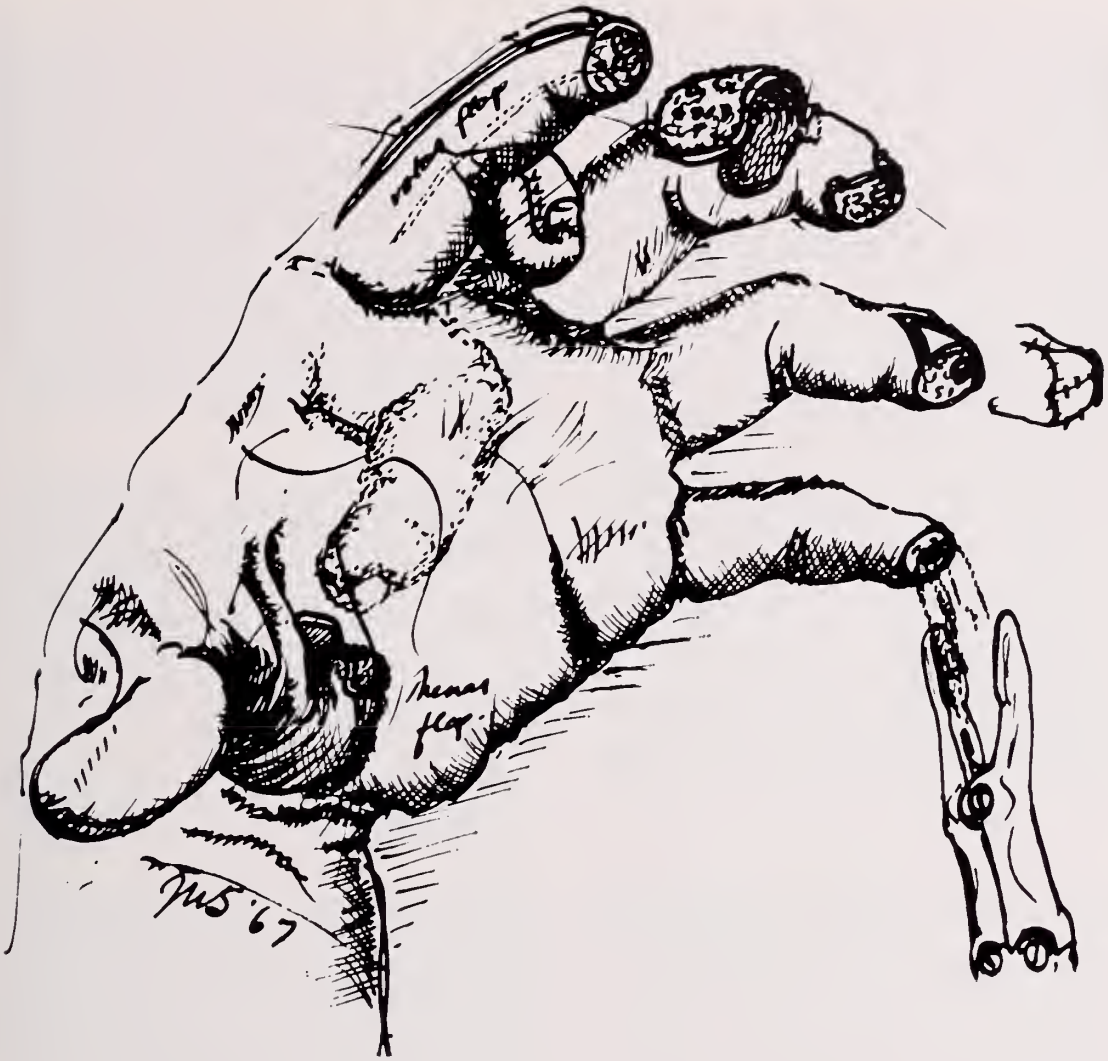


Fig. 10. — Little finger-bone shortened and wound closed. Ring finger—Kutler technique of V-Y advancement. Index finger—Cross-finger flap from dorsum of long finger; or elevation and advancement of a volar flap; or thenar flap.

Crushes

Crushed fingertips sustain a large amount of soft tissue damage with crush-lacerations frequently being present. Generally it is best not to suture these multiple and stellate lacerations as subsequent swelling may compromise the blood supply. Crushed edges also heal poorly. The fingertip should be dressed, immobilized and elevated.

Avulsions

An avulsion is a forcible tearing or wrenching away of a part. When this occurs at the fingertip it usually is termed an amputation and is so treated in this paper. In avulsion injuries proximal to the tip of the finger with normal distal tissue, the problem of sensibility is not so vital. If bone and tendon are exposed some type of flap coverage will be necessary and can be obtained from the dorsolateral margin of the injured finger and brought over onto the volar aspect (Fig. 15) or as a cross-finger flap. If the bone and tendon are not exposed, a split-thickness graft will suffice.

In the wedding ring type avulsion of the skin, subcutaneous tissue and distal phalanx, the finger is best sacrificed. Later the palm can be narrowed by digital transposition, moving the little finger metacarpal onto the ring finger metacarpal. If the patient insists on preserving the denuded ring finger, volar coverage can be obtained from a cross-



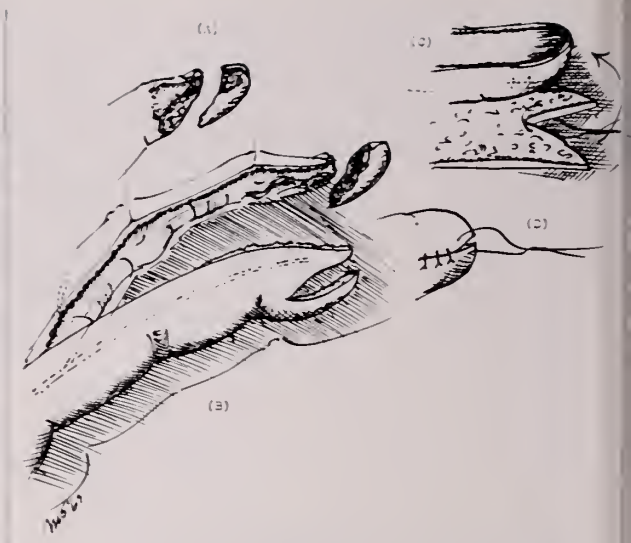


Fig. 12. — (a and b) Elevation of volar flap after volar oblique amputation. (c) The lateral and medial margins of the defect are sutured together, producing cupping of the distal flap. (c and d) The flap is then advanced to cover the distal phalanx and sutured to the remaining nail or nailbed.





Fig. 11. — (a) Mower Injury. (b) Thumb, index and ring finger covered by split-thickness graft. Tendon exposed necessitating cross-finger flap to long finger. (c) Note how contraction of split-thickness graft decreases the wound area. Note good contour and lack of shrinkage of pedicle flap.









finger flap encompassing almost the entire dorsum of the long finger. Dorsal coverage would then be obtained by implanting the finger into an abdominal pocket. Three weeks later the abdominal flap is dissected from the dorsum of the ring finger, leaving a fine layer of fatty tissue over which a split-thickness graft is applied. The cross-finger flap from the long finger is detached and inset (Fig. 16). Generally, as previously stated, this extensive resurfacing is not indicated.

Fractures

Fractures of the fingertips involving the digital tufts should be immobilized for four weeks. If the nail has been lacerated it should be reapproximated with sutures as this will anatomically reduce and immobilize the underlying phalangeal fracture. If the fracture occurs at the base of the distal phalanx proximal to the insertion of the flexor tendon, a transarticular K-wire is necessary to maintain reduction. Fractures involving one-half of the articular condyle should be opened and anatomically repositioned if any displacement has occurred. Untreated displaced interarticular fractures produce traumatic arthritis due to irregular stresses on the articular surfaces. These fractures can be reduced with a small K-wire or with a wire suture and drill holes. Multiple comminuted fractures of the distal or middle phalanx usually are best treated by an intramedullary K-wire. The frag-



Fig. 13. — Descending from top left (a and b) Motorbike chain injury—index, long and ring fingers. (c) Volar flaps elevated. (d and e) Four months postoperatively.



Fig. 14. — (a) Mower Injury. (b) Primary transmetacarpal amputation of index finger with preservation and reattachment of first dorsal interosseous.



Fig. 16. — Ring avulsion of skin, subcutaneous tissue and distal phalanx. Volar coverage from cross-finger flap from dorsum of long finger. Dorsal coverage obtained by abdominal flap coverage for three weeks. The abdominal flap is then dissected from the dorsum of the ring finger leaving attached a thin layer of fatty tissue that will accept a split-thickness graft.



Fig. 15. — (a) Joiner injury with avulsion of fragment of plantar skin and one-half the depth of distal interphalangeal joint of little finger. Interarticular cartilage removed and distal interphalangeal joint fused; flap taken from radial side of finger to cover volar defect and donor site grafted. (b) Four months postoperatively—dots outline flap, split-thickness graft stippled.

ments are molded into position and an external cast applied for six weeks. Tendon adherence to these fractures may be anticipated and require secondary tenolysis.

Summary

Injuries of the various anatomic structures of the fingertips and their treatment have been presented.

Photographs by B. English, Duval Medical Center, Jacksonville, Sketches by Dr. Snow.

References

1. Stark, H. H.: Mallet Finger, J. Bone & Joint Surg. 44-A (6): 1061 (Sept.) 1962.
2. Brown, H. A., and Brown, B. A.: Treatment of Peripheral Nerve Injuries, Rev. Surg. 24(1):1-8 (Jan.-Feb.) 1967.
3. Littler, J. W.: Principles of Reconstructive Surgery of the Hand, edited by J. Converse, Philadelphia, W. B. Saunders Company 4:1612-1673, 1964.
4. Sturman, M. J., and Duran, R. J.: Late Results of Finger Tip Injuries, J. Bone & Joint Surg. 45-A:289, 1963.
5. Fisher, R. H.: The Kutler Method of Repair of Finger Tip Amputations, J. Bone & Joint Surg. 49-A(2):317-321 (Mar.) 1967.
6. Snow, J. W.: The Use of a Volar Flap for Finger Tip Amputations, Plast. & Reconstr. Surg. 40(2):163-168 (Aug.) 1967.
7. Snow, J. W.: Mallet Finger Repair, Plast. & Reconstr. Surg. 41(1):89-90 (Jan.) 1968.

Dr. Snow, 2700 Riverside Avenue, Jacksonville 32205.

Psychodynamics of Narcotic Addiction

George W. Barnard, M.D. and Linda Ritch

While the medical profession has had a long-standing interest in narcotic addiction, in recent years this interest has been renewed because of the increasing social problems associated with addictions. Narcotic addiction is not limited to one clinical syndrome, but is found in patients with neuroses, psychoses and characterological problems. For this reason Savitt[1] has chosen to view addiction as a symptom complex with problems of impulsiveness as a core conflict of this maladaptive process. This view also was held by Fenichel[2] who found that, basically, addicts could not tolerate a tension state. His case studies indicated that the addict experienced tension as a primitive threat to his existence and that the narcotic served the function of decreasing the tension level. Thus viewed, the action of the drug was not to facilitate a state of euphoria but rather to abolish a tension state of emotional turmoil. In following this theoretical conception, Gifford[3] noticed an infant-like gratification achieved by the addict's use of narcotics. He discusses the addict's urgency to "reduce reality perceptions, abolish time sense and withdraw from the human contact" which are indicative of an early infant stage where anything other than gratification is thought to be unpleasant.

Rado[1] suggests that the problems of addiction should begin on the premise that it is not the narcotic itself but the addict's feelings of need for the drug that is indicative of addiction.

Rado believes that "drug addictions are seen to be psychically determined, artificially induced illnesses; they can exist because drugs exist; they are brought into being for psychic reasons."

In Rado's estimation, not one but two effects are attained from the narcotic. Not only is there the relief from painful stimuli, but there also exists a promotion of pleasure and therefore a euphoria producing effect.

Wikler[5] states that the pleasure associated with a euphoric state depends to some extent upon the satisfaction of primary needs in ways other than the use of soporific drugs. Therefore, the continuing use of such drugs relies on the subsequent gratification of primary needs through alternative methods.

Rado comments that the addict wishes for the narcotic to give him a pleasurable effect and yet at the same time realizes he must pay the price of heightened pain. The question arises as to why the narcotic is willing to pay the price. Rado suggests that many of the patients have initially had a "tense depression." This depression is characterized by heightened tension and an intolerance for suffering. He believes that in this depressed state the patient becomes more and more prone to seek release. The depression in turn acts to sensitize the patient for the drug induced pleasure state or relief-of-pain state.

Unfortunately for the addict, the state of elation does not last. Not only does the elation cease, but there emerges a heightened sense of depression, tension and guilt. The ego receives all the self reproaches for the neglecting of family and reality which took place during the elation period. Thus there begins the tormenting cyclic effect: inner-turmoil leads to elation with narcotics which leads to anxiety and depression. Rado remarks on a further tragic aspect of the cyclic course. Only the depressive state is dependable. It is not always possible for the addict to attain the elation even with higher dose levels of the narcotic. Despite all warnings from family and friends, the addict continues his self destructive course. Rado believes that this can happen only because "the elation has reactivated his narcissistic belief in his *invulnerability* and all his better insight and all of his sense of guilt are shattered on bulwark." At times this feeling of

From the Department of Psychiatry, University of Florida College of Medicine, Gainesville. Dr. Barnard is associate professor and Mrs. Ritch is research assistant, Department of Psychiatry.

invulnerability ends in death, with the patient taking a lethal dose of the narcotic in an effort to relieve the depressive state.

At this point it is worthwhile to give the psychoanalytic theory of the pleasure state of the young infant. Early infancy is a stage when frustrations, mainly bodily-oriented ones, are experienced, but then some caring-for adult fills the needs and the infant ascribes the resultant decrease in tension or pleasure state to his own being. Normally the infant learns to associate the relief of frustration with a caring-for person and still later he learns that he can enter into this two person system and meet some of his own needs. Thus there develops an increasing degree of trust of self and another person. At this crucial time, however, the process can become warped. The infant may have such a high demand level for need fulfillment that the caring-for adult cannot meet the needs, or for many reasons the adult may not meet a normal demand level. In either case the result may be setting the stage for subsequent depressive episodes. Also there may ensue the malignant distrust in self and others. This basic distrust distorts formation of satisfying relationships with others. The ego of this individual is reproached with the concept. "You once had the pleasure state without any effort, why not obtain it again?" It is at this level that narcotics can tragically enter the picture—through the simple means of ingesting a pill or receiving an intravenous injection, all the tension, turmoil and inner-suffering disappear. In place of the pain there emerges a heightened sense of pleasure, calmness and euphoria. At last the long lost infantile state of total gratification without effort is regained. Rado explains this euphoric satisfaction: "At the height of the elation interest in reality disappears and with it any respect for reality. All of the ego's devices which work in the service of reality—the ascertainment of the environment, mental elaboration of its data, instinctual inhibitions imposed by reality are neglected and there erupts the striving to bring to the surface and satisfy, either by fantasies or by floundering activity, all the unsatisfied instincts which are lurking in the background. Who could doubt that an experience of this sort leaves the deepest impression on the mental life?"

Savitt studied four adolescent heroin addicts through the process of psychoanalysis. He found a common pattern: all reported a feeling of being neglected and unloved by their mothers. Also, all the fathers were reported as being passive and inadequate men. While there was no evidence of physical neglect, each reported emotional turmoil in the home and all patients gave history of depression in early childhood. Of the four addicts in psychoanalysis with Savitt, only one completed treatment and made a recovery. Does this not in some way indicate that the addict operates on a more infantile level so that he has more difficulty relating through verbal psychotherapy or in psychoanalysis? In other words, is much of the conflict and therefore the needs, in great part at least, at a pre-verbal level? Certainly Savitt's patients tend to support this idea. One of these patients reported to the analyst, "Once I get something in my body I feel safe." Savitt states that the addict frequently reports dreams of body sensations of being wrapped in soft material, or warmth, and of floating. Thus the references are all bodily oriented. Savitt also notes in the addict characteristics of "greediness, insatiability and intolerance for delay in gratification." Disaster is almost here so get what can be gotten now since one does not know what is coming next. This insatiability plus the strong distrust that future needs will not be met, coupled with the increasing physiological tolerance, results in a spiraling effect in which the addict uses more and more drugs. Thus it appears that the increasing demand by the addict for the narcotic is a bipolar factor: insatiability plus physiological tolerance. The bipolarity has implications in treatment. Withdrawal alone only effects one aspect of the dual system. It in no way changes the infantile pre-verbal needs of the individual. Apparently these needs in some way are uniquely human. Other animals, such as chimpanzees, can develop the physiological tolerance from narcotics but have no inclination to return to them after withdrawal.

While Savitt reflects the belief that most addicts function at a rather primitive level, he emphasizes that some are more infantile than others and require the intravenous method for taking in the narcotic. In these, the need is either stronger or less delay for gratification is tolerated and so the oral route is rejected for the more rapidly effective intravenous route. In the latter type addict there is apparently little concern about or for the interpersonal object relationships. Rather, in a narcissistic way, the addict is more concerned about obtaining the impersonal narcotic which either gives him the euphoric

state or a relief from the inner tension he so desperately feels. Ordinarily when an infant is hungry, he cries, is fed by way of the oral route and receives satisfaction. It is only in the intrauterine state or in a medical emergency state that the intravenous route is used to satisfy the basic needs of nourishment. Yet the addict cries out for the intravenous route.

Wikler studied a subject during a period of experimental self-regulated readdiction to morphine in the Public Health Service Hospital in Lexington. The patient was told on October 11 he could have a single dose of any narcotic he wished and he began with the first 30 mg. injection of morphine. He appeared very happy and said the sensation was comparable to an orgasm. On October 13 it was explained to the patient that he was to regulate himself as to dosage. He requested two 30 mg. injections of morphine. By October 16, while still receiving 60 mg. of morphine daily, he was spending his nonworking time in bed reading, listening to the radio or dozing. His spontaneous references were to food and he compared the feeling before the "shot" to hunger and the satisfaction after the injection to satiation of hunger. The patient gradually increased the dosage to 115 mg. daily by January 17. He was informed that after 30 days he would receive no narcotics and that he alone would have to regulate the withdrawal. During the first week of the reduction period he increased his intake of morphine to 1380 mg. per day. In the last two weeks he changed to methadone and reduced the methadone intake to 35 mg. per day within the first week. Two days before all drugs would be withheld he returned to morphine and by the last day he was taking about 1000 mg. of morphine per day. Although the patient was offered psychotherapy after the drug was discontinued he refused to continue in treatment.

Wikler reports that the data obtained from his patient "shows clearly that opiates become attractive to the subject because of their remarkable ability to satisfy 'primary' needs. Thus morphine diminished hunger, reduced fear of pain and depressed sexual urges." Although the subject felt no desire for intercourse, he could maintain penile erections for long periods of time. This permitted him to satisfy the women he wanted to be with but from whom he did not desire intercourse. He compared the "thrill" of intravenous morphine to an orgasm and seemingly used it as a substitute.

In order to present a better understanding of the psychodynamics of a limited population we have reviewed the charts of three physicians who have been treated in our hospital within the past two years because of narcotic addiction to meperidine. Ages of these patients were 51, 32 and 65. All were extremely hard workers and often spent 18 to 20 hours a day at their work. Each of these patients had received previous treatment for drug addiction and had experienced relapses. Two of the three physician-patients left the hospital against medical advice and only one remained in therapy long enough to receive any significant improvement in terms of changing his patterns of adaptation and his relationship with other people.

In line with the findings of Savitt concerning the early deprivation of a parental figure, it was noted that two out of the three of our patients experienced an early loss of mother. One mother died at the time the patient was born. One left or deserted the patient by divorcing his father when the patient was age three and the third patient was caught in a strong dependency bind with his mother. We found that our patients focused on physical symptoms or bodily oriented concerns and all three had had past illnesses with which they were continually preoccupied. Two of the three had a history of duodenal ulcers and had received partial gastrectomies. One of these patients had developed the duodenal ulcer at age nine years. All of them reported a fear of financial loss in the family during childhood and all three were excessively concerned with money during childhood.

When one analyzes the characteristics of these patients, either when they describe themselves from psychological test data or if the data is obtained from others, there develops a rather consistent picture. None of the patients had an ability to form a good relationship with his spouse and it appeared that both the spouse and the patient were unaware of the other's needs and there was a barrier between them. The patient was even more unaware of his own needs. It took one patient several months to become aware of his strong fear of others and his need to please them. Some characteristics obtained from several sources for the patients were tenseness, anxiety, insecurity, worry, perfectionism, submissiveness, manipulative ability, having an outward charm, suspiciousness, guardedness, inability to tolerate boredom and having hostility but denying it. All the patients were unable to express anger openly

or directly except while intoxicated with alcohol. None of them had a history of expressing anger while on other narcotics. The patients believed the environment hostile and attempted to placate and please others. Even when the patient was doing a good job according to others, he felt inadequate and displeased with himself. There was a fear of responsibility and the patient expressed a feeling of being rejected by others, although intellectually he did not believe this to be true. As mentioned previously, there was a fear of their own anger and they felt guilty over past expression of any degree of anger. Males were seen in their eyes as competitors whereas females were seen in a more ambivalent manner. Females were seen as controlling and dominating yet at the same time protective. Women were seen as a source for fulfilling dependency needs and not for sexual gratification. Conflict with women was clearly evident in family therapy sessions, in their relationship with the nurses and in their general refusal to work with the female occupational therapists.

When one of the patients was asked why he took morphine, he reported that the medical textbooks describe addiction as benign (thus strong denial). He wanted to get something out of it and not get caught (thus a hostile slap at society) and that he wanted to take a "shot" at a party and see people's reaction (thus a desire to shock others and exhibit self). In line with the strong oral component in the addict, this patient reported a feeling of being restricted, a feeling that he must do something, like wanting to eat yet not being hungry, and he did not know what to do. Nothing pleased him or gave him a "thrill." He believed that he had to do things by himself yet he feared that he would fail.

Conclusion

It is important for all physicians to recognize that regardless of any addict's education, professional or social status, the addict is basically a dependent infantile character. The psychodynamics tend to focus on conflicts at an early stage of life and often this seems to be at a pre-verbal level of experience. Since the conflict has been at a period of life prior to the development of language this makes it even more difficult for the patient to express himself or to be aware of the conflicts. Perhaps this, in part, explains why all psychotherapeutic procedures have tended to be so ineffective. It is important that every possible effort be made by the medical profession to obtain further insight into the psychodynamics of the emotional state of the addict. While making use of every possible treatment procedure now known, hopefully more effective treatment techniques will be developed.

References

1. Savitt, R. A.: Psychoanalytic Studies on Addiction: Ego Structures in Narcotic Addiction, Psychoanalytic Quart. 32: 43-57, 1963.
2. Fenichel, O.: The Psychoanalytic Theory of Neurosis, W. W. Norton & Co., Inc., 1945.
3. Gifford, S.: Sleep, Time and the Early Ego, J. Am. Psychoanal. Assn., VIII, 1960.
4. Rado, S.: The Psychoanalysis of Pharmacothymia (Drug Addiction), Psychoanalytic Quart. 2:1-23, 1933.
5. Wikler, A.: A Psychodynamic Study of a Patient During Experimental Self-regulated Readdiction to Morphine, Psychiatric Quart. 26:270-293, 1952.

▶ Dr. Barnard, University of Florida College of Medicine, Gainesville 32601.

Pleural Drainage for the Ambulatory Patient

Robert Keith Fabric, M.D.

The purpose of this article is to present a technique which would be used in the treatment of air and fluid in the pleural cavity and which would render the patient fully ambulatory and easily transportable. At the present time, the Heimlich[1] one-way flutter valve connected to a routine chest tube is gradually replacing the cumbersome underwater chest tube bottles as an accepted treatment for simple thoracic drainage procedures.

From the Department of Surgery, University of Miami School of Medicine, Jackson Memorial Hospital, Miami. Dr. Fabric was surgical resident, Department of Surgery, at the time this article was prepared. He is currently on active military duty as Captain, U.S. Air Force.

Utilizing the present principle, a chest tube attached to the Heimlich valve is joined with a conventional disposable urinary walking leg bag[2] into which both air and fluid can escape (Fig. 1). When the bag is opened periodically for elimination purposes, the fluid easily gravitates out and the air is removed by physical compression of the bag. To obtain the most favorable results, the tubing should be tailor-made for the patient to avoid redundancy and possible coiling which would interfere with normal flow.

The advantages of this approach are obvious for those patients who would be able to ambulate

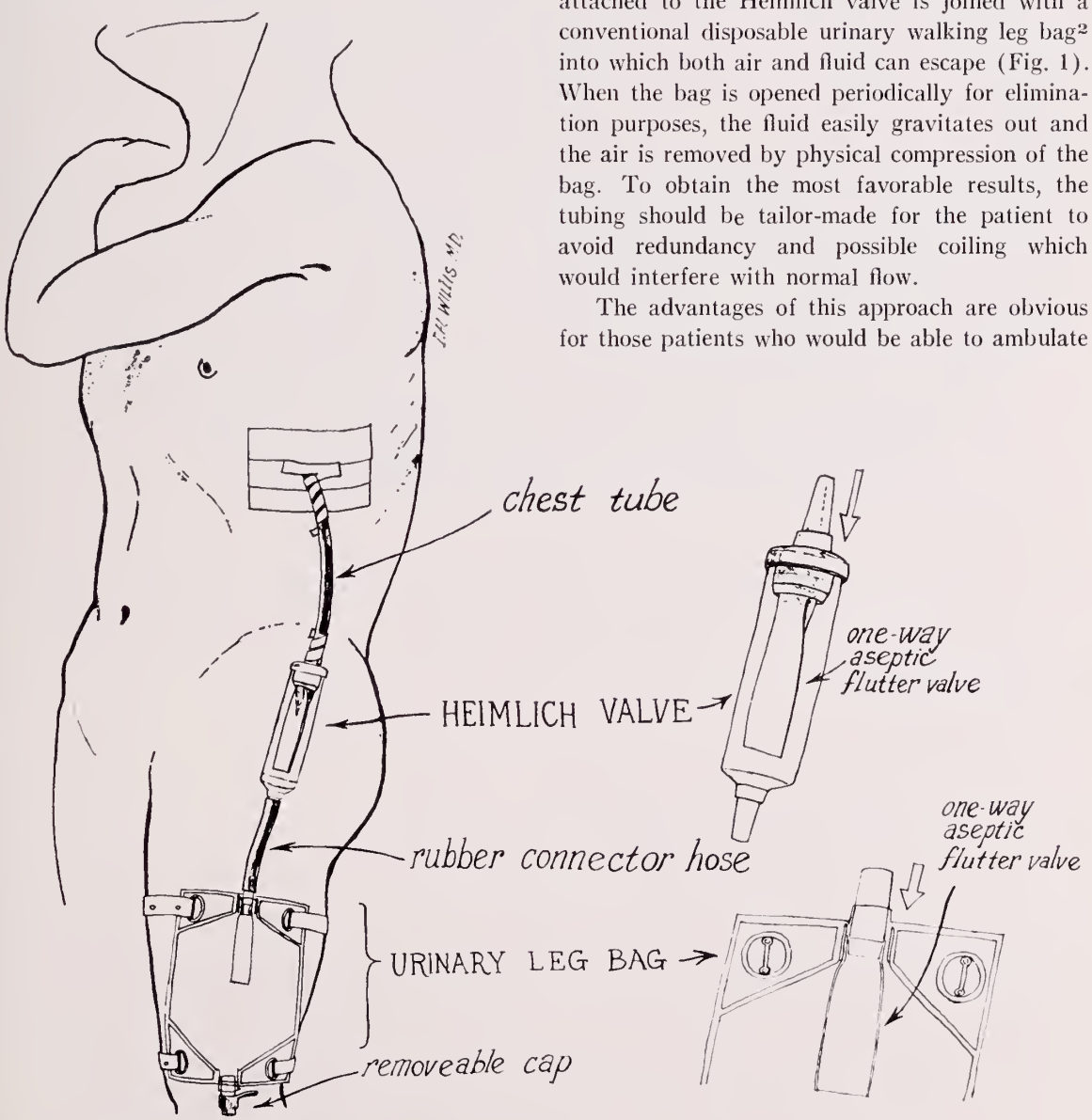


Fig. 1. — The tailor-made drainage apparatus readily conforms to the body curvature, facilitating unimpeded movement.

about the ward wearing this device. It is particularly beneficial to the elderly patient who would otherwise be bedfast and therefore subject to the complications of thrombophlebitis and pulmonary emboli. Among other dividends, one should consider the ease in nursing care, accuracy of measuring input and output and use with self-care patients. Special diagnostic studies requiring patients to move to rooms other than their own are now more feasible due to the ease of transportability.

Summary

A technique is proposed to avoid the complications and discomfort of limited activity imposed upon a patient when water seal chest tube drainage is used for air and/or fluid in the pleural cavity. This technique also can be used in the treatment of pericardial effusions, peritoneal fluid and aseptic drainage of uretero-ileostomies. Utilization of this new approach reduces the amount of nursing care required for these patients.

Acknowledgements

I am very much indebted to Dr. Carlos Lombardo for his suggestions and critical evaluation of this manuscript and to Dr. Irving H. Willis for the illustration.

References

1. The one-way flutter valve, made by Bard-Parker Company, Inc., is disposable, inexpensive, aseptic and of light weight.
2. A urinary leg bag, such as the one made by Sterilon Corporation, has a one-way aseptic flutter valve. This is an important safety feature, but when used alone, without the Heimlich valve, has proven to be ineffective.

Dr. Fabric, Chemical Hazards Branch, Toxic Hazards Division, 6570th Aerospace Medical Research Laboratories, Area B, Wright-Patterson Air Force Base, Ohio 45433.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

THE RESTLESS DUODENUM...



DUODENUM—(Conventional X-ray) The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive. Is this duodenum normal?

Pro-Banthīne®

brand of

propantheline bromide

For fifteen years Pro-Banthīne has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthīne has reestablished its pharmacologic effectiveness in facilitating diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthīne. The duodenum was intubated. Pro-Banthīne in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis, and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

...AT REST



SAME DUODENUM—(Hypotonic X-ray) Pro-Banthine-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

Contraindications: Glaucoma; severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology 89:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. 50:445-460 (May-June) 1955.

SEARLE *Research in the Service of Medicine*


on call...
Keflin®
Sodium
Cephalothin
Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206

When it's time for Thorazine® brand of chlorpromazine



...can you depend on less?

For profound calming effect in moderate to severe mental and emotional disturbances of everyday practice.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

©1967, 1968 Smith Kline & French Laboratories

Smith Kline & French Laboratories, Philadelphia SK&F



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



Emetrol®
phosphorated carbohydrate solution
emesis control

ROERER WILLIAM H. RORER, INC.
Fort Washington, Pa.



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 - 324-4882

Florida Medical | editorial

Nurse-Physician Teamwork

Clyde M. Collins, M.D.

The success of the first Florida Medical Association-Florida Nurses Association joint conference held last June at the Robert Meyer Motor Inn in Orlando undoubtedly is due in large measure to the excellent planning of Dr. James Walker, chairman of the FMA Committee on Nursing, but it also is a tribute to the past chairman, Dr. Thomas C. Kenaston Sr.

Entitled "New Horizons in Nurse-Physician Relations" and sponsored by a grant from Merck Sharp and Dohme, the conference atmosphere was set by the inspirational address of Dr. Edward Annis, member of the AMA board of trustees. The humorous monologue of Wayman Parker, Merck Sharp and Dohme region manager, kept everybody laughing and he recounted anecdotes so rapidly that one hesitated to write them down for fear of missing the next one.

In a more serious vein, many remarks were made which, if considered carefully and in context, would do much to stop these two organizations from going their separate ways. The splitting of those attending into small discussion groups with a well qualified moderator gave each person ample opportunity to present his or her viewpoints.

Several thought-provoking suggestions were brought out by one or more discussion groups. Some suggested monthly meetings within the hospital of a joint MD-RN patient care committee and further suggested a member of the hospital administration be included on such a committee. Others said not only should hospital boards include a physician, but also should include a senior RN as a member.

Many times the question arose, "What can be done to relieve the RN of routine chores so that she can spend more time with the patient?" One reply was that the professional nurse assert herself by defining the area of competency in which she can best serve, this concept presently being in evidence in some intensive and coronary care units.

Other questions were: "What does the nurse do that enables the physician to give good patient care and, conversely, what does she do that hinders such care?" and, "What does the physician do that helps or hinders the nurse?" It also was brought out that the term "nursing service" should be carefully redefined, as should the role of the RN. Finally, it was asked, is not the key to better nurse-physician relations a clearer understanding of the nature of the hospital's job—a job which should be oriented toward providing for the patient the best treatment in the most efficient and most reassuring manner?

Nurses were critical of the members of their own profession, saying that more time should be spent with the patient and that this time should be 90% listening. It was suggested that instead of saying, "I can't stand that patient," the nurse should learn to adjust her personality to that of each patient. It was further recommended that specially trained nurse-consultants move about each hospital to educate other nurses. It also was suggested that each two-year graduate nurse, of whom 250 graduate in Florida annually, should have an additional year of internship training under the supervision of a professional RN.

The conference prompted me to peruse the literature, and in so doing I found a number of interesting articles which made me ask myself, "Why didn't I know this, and why didn't I read this when I first started into practice?" One author flatly stated that a dangerous communica-

tion gap exists between the nurse and the doctor. For example, the nurse often resents the younger doctor because he has not yet reached the point of being aware that the patient cannot get well solely through physician care, but that the patient can only recover through the efforts of the entire professional health team. Many nurses also believe it is the responsibility of the physician to adequately discuss with the nurse in charge all of the peculiar needs or symptoms of each of his patients and the significance of such. As the nurse views it, in doctor-nurse teamwork the successful team physician is communicative, coordinative, cooperative and conservative of the present limited nursing resources. He does his own job well, works well with his colleagues and follows established policies. The poor team physician, on the other hand, accustomed to evaluating the needs of his patient and making independent decisions, often is frustrated by cumbersome hospital methods. Slashing red tape to increase his own efficiency and to benefit his own patient, he often appears insensitive to the needs of others, both patients and co-workers.

One answer to this problem has been developed by the University of Kentucky and is facilitated through the existence of a medical faculty member known as the "physician-patient care coordinator." He functions first by simply being available. Associated with him is a liaison nurse, freed from tasks of other assignments, who concentrates on identifying person-oriented problems and communicating them to others on a team. At the University of Kentucky teaching hospital the physician coordinator and the liaison nurse form the continuing nucleus of patient care conferences. A more descriptive term for what takes place may well be patient management conferences, as discussion is focused on the patient's problem as a result of the disease rather than on the disease itself.

Other articles contain basic as well as finer points that may be utilized to improve the working relations between these two arms of medical service. A further review of the literature may present many ideas for discussion which could do much to improve nurse-physician teamwork and which would serve to enlighten discussions of any joint MD-RN meeting, be it another statewide meeting or one on a regional or local level. Here's hoping that day is not far away.

From the Editor

Franz Stewart

Shadowy Signs

These are glimpses, as memory and time permit the truth. The circumstances cannot be recalled sufficiently to apply to any individual.

Thomas B. was beyond reproach. His 20 years of driving an intercity bus were without mishap. On this day he wandered from his usual route, and his report of receipts was all wrong. Could he really have filched funds after all these years?

William C. was using cleaning fluid in a lazaret aboard a small vessel in the bare July Florida sun. He fainted. He was disturbed thereafter because he seemed to forever smell the odor of the fluid.

John W. was prone to overindulge on the least excuse or because there was no excuse. One night he was found sitting by his parked car, his head bruised, his arm broken. He said he had fallen. On examination there were the expected bruises, fracture, tremulousness and a slight variation in the size of his pupils.

These three men seem to have self evident problems, but they have one common denominator in shadowy signs. Each had a brain tumor.

The Eye Over Florida

The Hurricane is a part of the personality of Florida. When everything is battened down, loose objects which might fly against a window removed, and fresh water and supplies all safely stored; then comes the family time.

The common threat, the mutual preparations, the civic needs, all bring the people together. There is a strange, warm, community of feeling between all of us at this time. We are each caring for our own, but willing to help each other.

After the effort of preparation, all is ready; we sit together about the table, waiting, ready for what the storm will bring. This feeling must be experienced to fully enjoy this warmth of companionship.

All together we watch for the Eye of the Hurricane to pass over us. An exciting time which brings us all close in the snugness of home. The Eye over Florida.

Surgical Technic

For combatants, the closer to combat the better the medicine and surgery. This is well proved, over and over again. Skilled effective surgery must be available immediately. The American experience demonstrates this in both past and present wars.

But there is another element, a common denominator for good medicine anywhere. Let a surgeon from a field hospital 1,000 yards from the fighting front on Okinawa talk to us about it:

Do not lose sight of the value of morale in surgical patients. The will, determination and effort on the patient's part to live and recover completely are major items in so doing. Every effort should be exhausted in building and keeping up morale. This need was especially exhibited to me during my combat experience. . . .

This voice is from Panama City in this Journal in September, 1948. What say you, William C. Roberts! □

CONVENTION PRESS

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

Whatever your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let Convention Press help solve your printing problems by intelligently assisting on all details.



The Bettman Archive

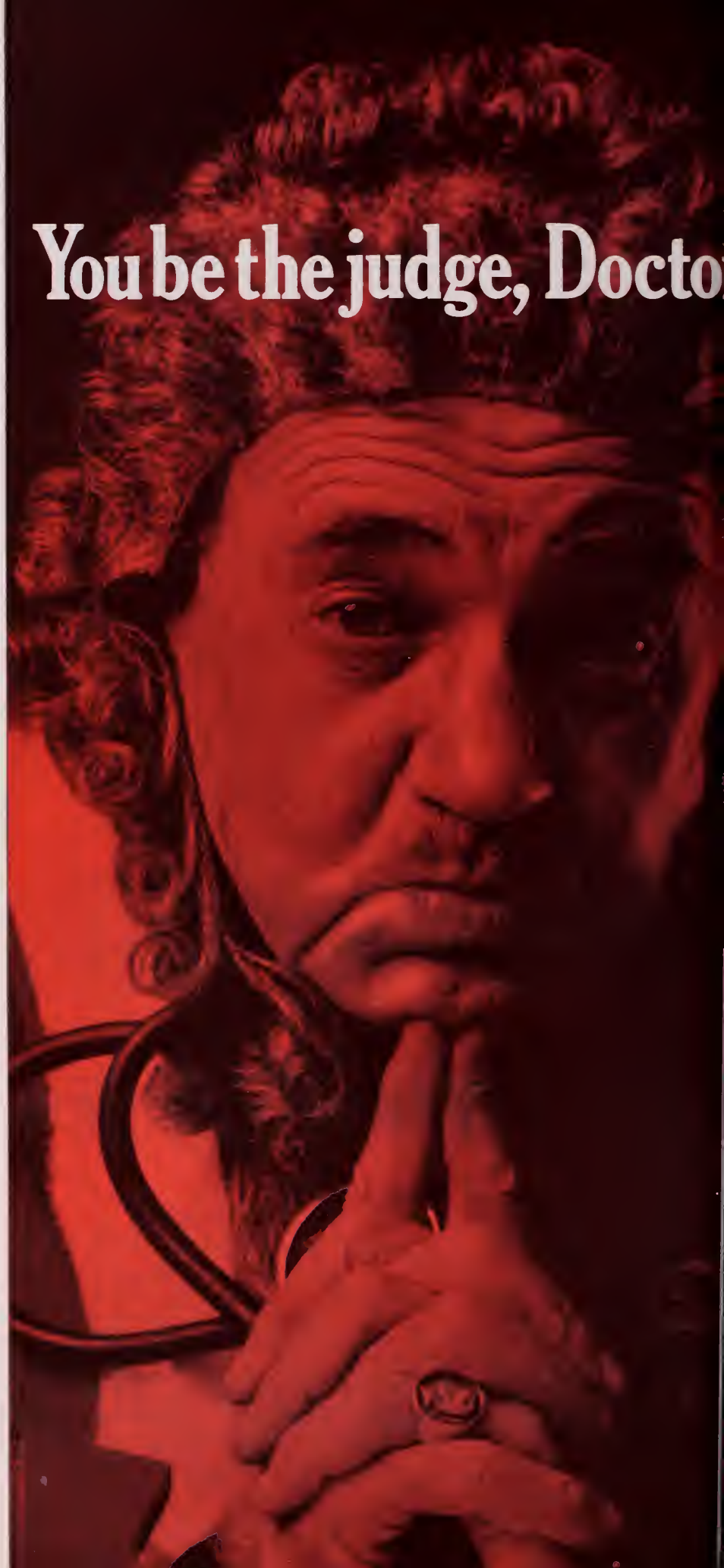
Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

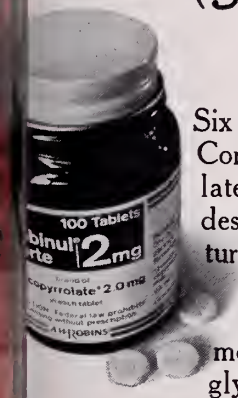
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

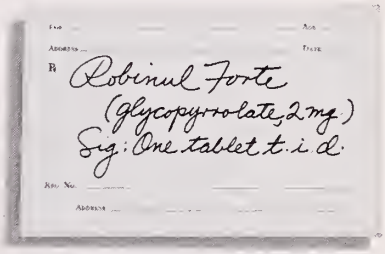
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and a marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.

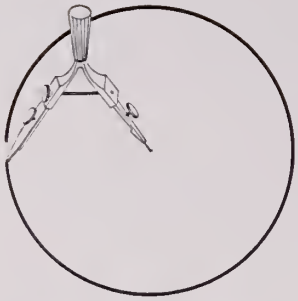


Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Need an office wing?



Consult an architect!

Need an extension?



Call the phone company!

Need optical services?

GUILD Rx OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Specialized services demand specialized knowledge. That's why an architect is consulted when you want the construction you contemplate to be properly planned. It's why you call the phone company when you want your telephone service extended or revised . . . and it's why you should call on your Guild Optician for optical services of any kind.

It's not just by accident that the Guild Optician is an expert. His qualifications are based on knowledge and experience, his will to serve the doctor, his ability to handle not only the routine problems of after-service for your patients, but also the unusual.

When you write a prescription, above all you expect to have that Rx properly filled so the patient obtains the full benefit of your professional services. You also expect to have your patient receive after-service for the life of his glasses. That's why it's wise to call on an expert — your Guild Optician. *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

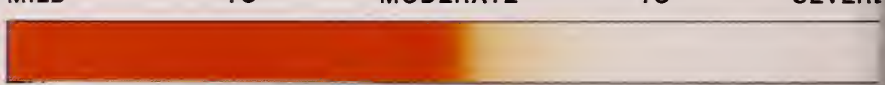
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

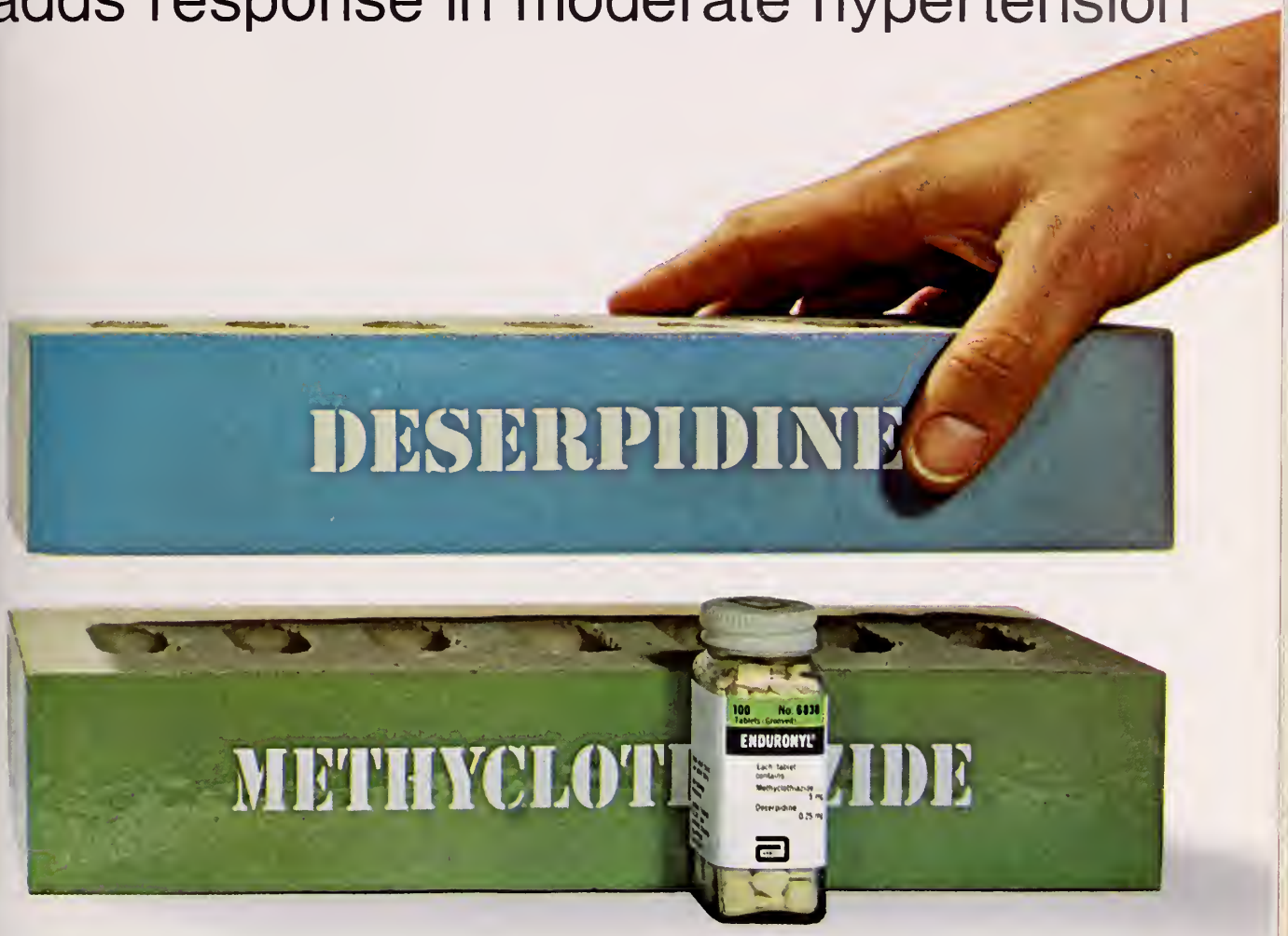
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

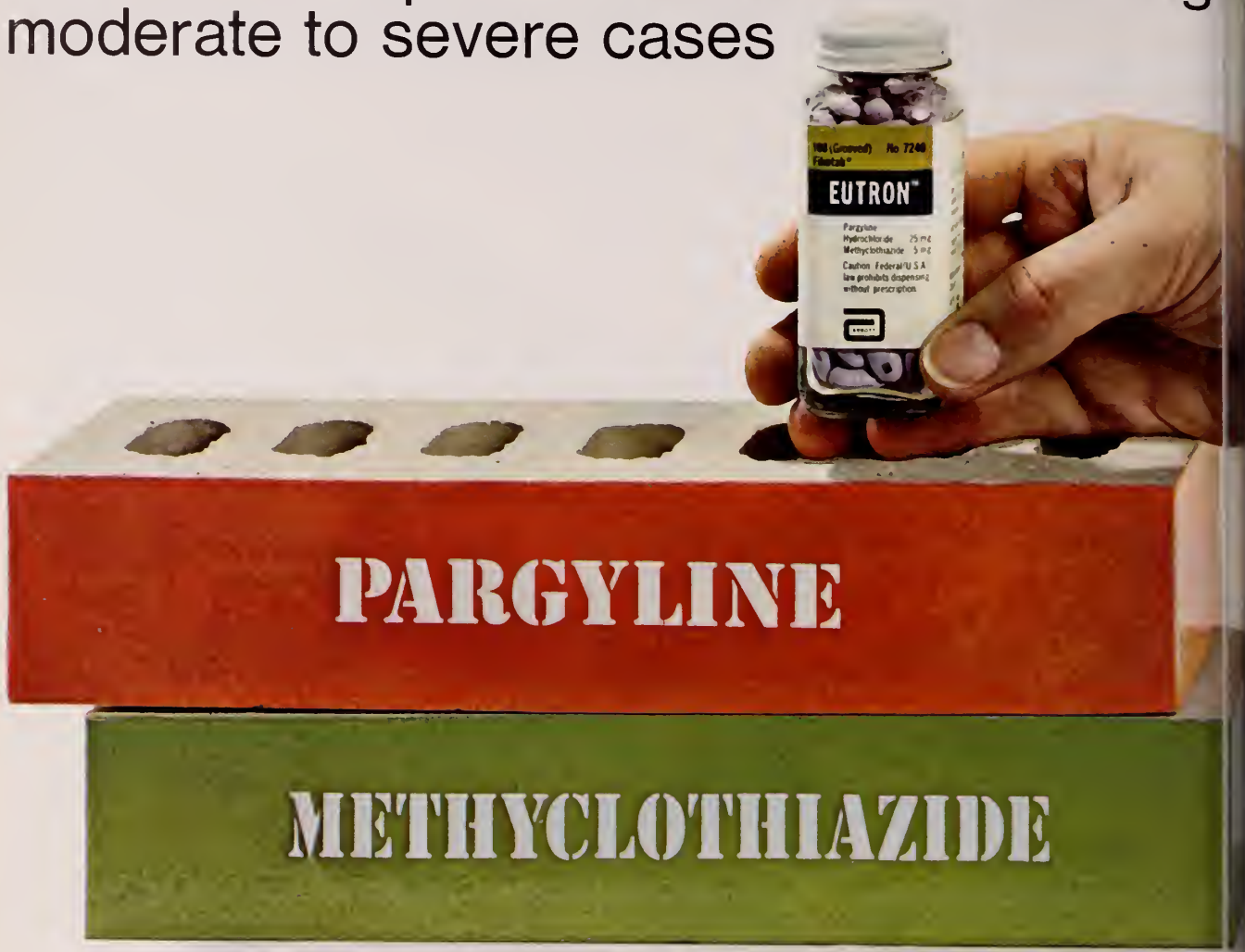
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

ABBOTT

TM-TRADEMARK



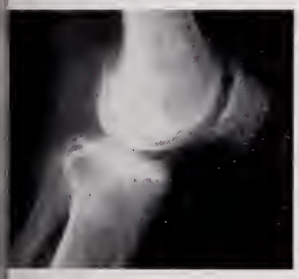
Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in th elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles o face may be minimized by withholding dieta salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued wit the appearance of edema. The drug has bee associated with peptic ulcer and may reacti-

'Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

a latent peptic ulcer. The patient should e structed to take doses immediately after s or with milk to minimize gastric upset. rash occasionally occurs. If it does, ptly discontinue the drug. Agranulocy-, exfoliative dermatitis, Stevens-Johnson rome, Lyell's syndrome (toxic necrotiz-pidermolysis) or a generalized allergic tion similar to a serum sickness syn-e may occur and require permanent drawal of medication. Agranulocytosis occur suddenly in spite of regular, re-ed normal white counts. Stomatitis, sali-gland enlargement, vomiting, vertigo and or may occur. Leukemia and leukemoid ions have been reported. While not defi-attributable to the drug, a causal rela-hip cannot be excluded. Thrombocyto-penic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

Geigy

(B) 46-800-A

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-5606AR

Florida Medical | comment

Feverish Recollections of 25 Years Ago

Fred A. Butler, M.D.

The death of Dr. Mark Boyd, long a Floridian and author of the authoritative book "Human Malaria," calls to mind wartime experiences with this disease. Dr. Fred Butler was an outstanding leader in epidemic disease control in the South Pacific and was asked to comment —Ed.

Many Florida physicians will recall the Solomons, that chain of large, dark green, mountainous and somehow threatening islands. Wet coconut groves and black mud will not be forgotten. Here the Japanese reached their high water mark in 1942-43 and ebbed back, and here and in the New Hebrides chain immediately to the south two wars were fought.

Knowing the Japanese were already in the Solomons a few hundred miles away, a Marine battalion was rushed to the island of Efate in the late spring of 1942. The commanding colonel chose strategic ground in a swampy valley adjacent to large coconut plantations and numerous Tonkinese (Vietnamese) dwellings. To his total dismay his battle ready troops became ill in large numbers, and in two months virtually all, including the colonel, were temporarily out of the war. Thus began the second war with malaria which continued to Okinawa.

In August 1942 the First Marine Division landed in Guadalcanal, made history, and was evacuated several months later almost 100% malarious. Essentially the same fate befell their Army reenforcements and many of their replacements. A steady stream of hollow-eyed, lean, febrile men were flown to American hospitals to the south, and American doctors learned about malaria first hand. The uses of quinine, not to mention the relatively new drug Atabrine,* were poorly understood by most of the physicians on the spot, and the drugs were often in short supply. Responsible commanders trying to fight an unfamiliar war against a stubborn enemy became irritated and impatient with the high sickness rates. Men were accused of malingering, and many officers assumed the attitude that if malaria was ignored it would go away. All resisted pleas to divert men to malaria control and to change battle plans.

Sound information and medical intelligence gradually became available. United States, Australian and New Zealand physicians contributed much advice, and the monumental volume "Human Malaria," authored by the late Dr. Mark Boyd of the Rockefeller Foundation and Tallahassee, had many of the answers when there was time to read. Dr. Franz Stewart will recall treating many malaria patients at the U. S. Naval Hospital at Espiritu Santo, as he was a pioneer in developing a clear clinical picture of South Pacific malaria. Dr. L. L. Parks, long of the Florida Board of Health, then Colonel Parks, MC, USAR, was in charge of field malaria control operations in Guadalcanal and later at Bougainville, and many other Florida physicians were undoubtedly in the area and saw their share of malaria.

Despite early medical disasters due to lack of drugs, experience and organization, great resources of qualified men, supplies and equipment gradually were made available in the usual American tradition. At one time in early 1944, 6,000 men were devoting most of their time to effective malaria and mosquito control throughout the South Pacific.

Valuable lessons emerged. The New Hebrides and Solomons Anopheles mosquito avoided moving water, consented to breed in quiet pools but favored tin cans, coconut husks and similar myriad water containing debris common about troop and native settlements. Drainage, periodic flushing of stagnant water, oil spraying and clean-up programs near troops were necessary and gradually organized. Little of this was possible in fluid battle areas, and other means had to be devised such as mosquito repellents, protective clothing and bed nets, but at their best, these measures

*Atabrine (quinacrine), Winthrop Laboratories

could not protect against some degree of infection.

Drug suppression and treatment of South Pacific malaria is a fascinating chapter. It was well known that Plasmodium vivax caused a relapsing type of malaria, and Atabrine, according to the literature, could suppress clinical malaria, preventing fever and chills. The duration of the relapse period was unknown. Also unknown was the safety factor in using Atabrine over long periods. The drug was found to be very effective when taken daily but when stopped at six months, one year and even up to two years, disabling relapses resumed. Three to four years was finally determined to be the maximum life of this vivax strain in the human body. Negroes were thought to be immune from vivax malaria because of some ancestral protection, but were found to develop the disease and relapse in the usual manner. Suppression of malaria required daily ingestion of Atabrine, resulting in a yellow jaundiced-appearing skin. Failure to take Atabrine in a combat area was a form of malingering, and the presence of a suitably healthy yellow skin was checked by officers and was a measure of troop morale. Appearance of the worldwide outbreak of infectious hepatitis among troops in 1943 caused confusion and fear of Atabrine toxicity until clinical differences were pointed out. Chloroquine did not become available until 1944 and, although highly effective as a suppressive agent, did not figure in the South Pacific campaigns.

P. falciparum was known to produce a clinically severe form of malaria (malignant tertian). Initially feared, it was not of great military importance for a reason discovered in the South Pacific and possibly elsewhere. Early in the war when naive and unfortunate efforts were made to take malarious troops off Atabrine in rest areas, it was noted that numerous vivax recurrences developed but falciparum relapses were few. From this observation it was established that a short period of Atabrine suppression treatment actually cured or eliminated falciparum malaria from the body.

From the vantage point of roughly 25 years, it is now interesting to read that the World Health Organization is beginning to express optimism for eventual elimination of malaria. In all likelihood this will occur primarily through drug suppression. Atabrine was the synthetic forerunner of a wonderfully effective series of new drugs for control of malaria. Without Atabrine or a similar drug





Robitussin-DM Cough Calmers

Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM® Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

the land campaigns of the South and West Pacific and Asia during World War II probably could not have been fought in the manner possible, and the complexion and duration of the war might have been quite different.

▸ Dr. Butler, 1262 Third Street South, Naples 33940.

Notes from Vietnam

I thought you might be interested in what this "crazy GP from St. Augustine" is doing over here in wartorn Vietnam . . .

Well, I arrived in Saigon on the 15th of June, after a trip to Hong Kong, with nine other VPVN's (Volunteer Physicians for Vietnam). Dr. Charles Moseley of the AMA, our project director, did a great job of briefing us and rolled out the red rug in San Francisco—we even had coffee at the Clipper Club in the Pan Am building.

We arrived in Saigon on the day that the VC threatened to send in "100 rockets for 100 days" and we felt 40 of them land, plus watching the battle of Saigon from our rooftop (Hotel Miramonde). Some of the guys slept in the showers because they are well protected. The flares lit up the sky all night—hundreds of them—at $88.00 a throw. Uncle Sam fights an expensive war. Then the B52's shook the earth for about 15 minutes and the rockets quit—this was repeated the next night. We were all briefed and got our ID cards and our province assignments. Mine was in Vinh Binh Province in the heart of the Delta along the Mekong river tributaries, 80 miles south of Saigon. It is the seat of the original dispute between the French and the Viet Minh in 1945.

Our job here is to advise the local medical personnel and the Medicine Chief (pronounced "chef") as to our methods of medical practice and not to step on their toes. . . . This is tough at times when you have a bunch of military casualties and you want to work fast. Amputations are the rule and this is because of concussion injuries from such things as land mines, mortars and booby traps. We treat the civilians and the Vietnamese military—no U.S. soldiers. The work is hard and the facilities, other than the surgical rooms, are primitive—but that's why we do a lot. The American doctor is used to improvising and he usually does well here. The weak spot as in the States is the nursing. You may or may not have enough help and when you do, they don't always give the medication you

prescribe, but we save more than we lose. Our greatest frustration is that they won't give blood. I lost two patients so far only because they needed blood. I have not seen any Napalm burns, contrary to VC claims.

There is activity about and we cannot leave our compound except in the daytime and only for short distances. The B52's (only operating in the Delta now since the "Peace Talks") shake us up occasionally—what terrible power!! and accurate too!

The language is tough but I'm learning—one of the greatest problems is that "Did you have a BM?" in Vietnamese is very difficult to say. We have many bowel perforations from shrapnel and you can see what a problem this is.

Well my tour goes on—I believe our program is a great help. The Vietnamese know we are here voluntarily without pay and we think they appreciate it—anyway, we got several palm trees and banana trees given to us to prove this. Most of all we jack up the military people here, because they are impressed to know that we have volunteered to help and are heartened by this because they had begun to doubt about patriotism and support from their own countrymen.

I didn't know that I would "bend your eye" so long, but maybe this information will help raise the Florida census from three to more. New York and California have really outstripped us! And yet this country is just like Florida—same flora and climate. We ought to keep one hospital staffed by Florida physicians at all times—the work is rewarding and an experience of a lifetime.

James J. DeVito, M.D.
Phu Vinh
Vietnam*

Continuing Medical Education Through Educational TV

Beginning this month, the Board of Regents of the state university system and the University of Florida College of Medicine will present seminars each Tuesday and Thursday for physicians on open educational television.

The initial programs will be given on stations WUSF-TV, Tampa (Channel 16); WFSU-TV, Tallahassee (Channel 11) and WUFT, Gainesville (Channel 5). The programs will be made available

*Mailing address: Advisory Team 57, APO 96314, San Francisco, Calif.

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064



When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

to other educational television stations if they want them.

Open educational television is being used in continuing medical education in other parts of the country, most notably in South Carolina, Utah, Oklahoma and New York. It is difficult to tell whether the programs have actually assisted physicians in keeping abreast of the latest techniques and information.

In Florida we are going to try to remedy this by making a real effort to study the educational value, pertinence, timeliness and technique of presentation of the programs. Selected physicians in the various viewing areas will be polled to give their opinions of the seminars and suggestions for improvement. We hope that this critique will help to clarify whether or not educational television can be a useful part of a physician's overall postgraduate educational program, and if it is how it can be most effectively utilized.

Complete program schedules for the period September 1968 to February 1969 may be obtained by contacting me.

THOMAS D. BARTLEY, M.D.*
GAINESVILLE

Double-Take

The June issue of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION prompted a double-take and a pleasant one, I must report.

I certainly admire your new designs, particularly the attractive front cover display and I am sure you will receive many comments about it.

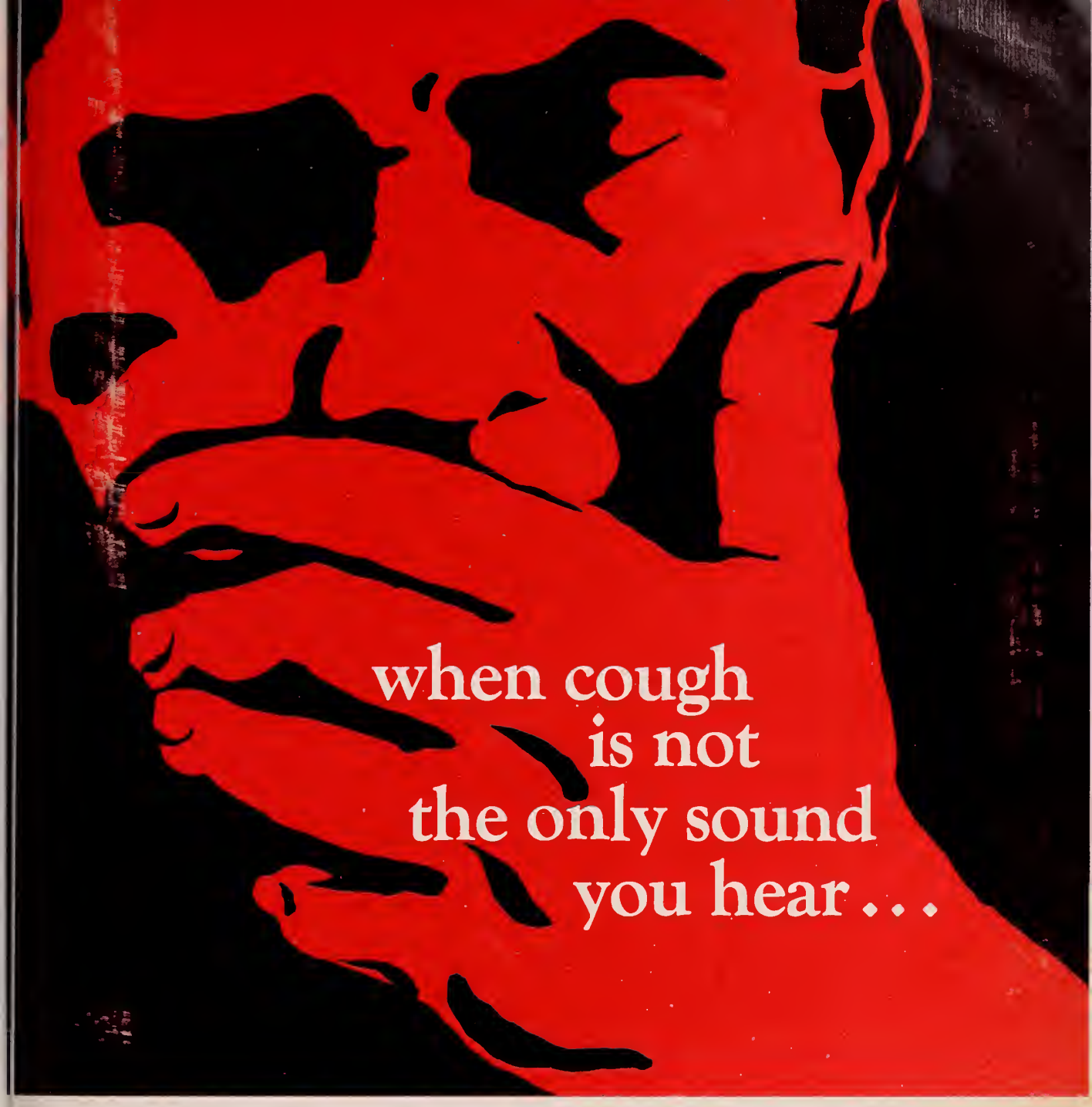
EDWIN F. SMITH
EXECUTIVE SECRETARY
MEDICAL ASSOCIATION OF GEORGIA

Delighted

Dr. Davis and I are delighted with the final presentation of our article "Drug Induced Photosensitivity." Certainly you and the printers are to be complimented on the final layout and the color reproduction. Further, we appreciate the very excellent cooperation and assistance which you gave thus making it possible to publish this article in what I believe is record time.

VICTOR H. WITTEN, M.D.
MIAMI

*Assistant Dean for Postgraduate Medical Education, University of Florida College of Medicine.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

new evidence for TAO® (triacetyl-oleandomycin)



a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

ROERIG Rx
J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reactio (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticaria type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significan disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-9

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®

(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Florida Medical | feature

Florida Regional Medical Program

H. Phillip Hampton, M.D. and Samuel P. Martin, M.D.

On Oct. 6, 1965, the President signed Public Law 89-239. It authorizes the establishment and maintenance of Regional Medical Programs to assist the nation's health resources in making available the best possible patient care for heart disease, cancer, stroke and related diseases, the cause of 70% of the deaths in the United States. The legislation was shaped by the interaction of at least four antecedents: the historical thrust toward regionalization of health resources; the development of a national biomedical research community of unprecedented size and productivity; the changing needs of society, and finally, the particular legislative process leading to the Act itself. It is not a program imposed by Washington, but rather is designed to establish a close bond between medical education and practice at the local level.

The Act turns away from the idea of a detailed Federal blueprint for action and presents a concept of "regional cooperative arrangements" among existing health resources. The legislation establishes a system of grants to enable representatives of health resources to exercise initiative to identify and meet local needs within the area of the categorical diseases through a broadly defined process. The grants authorized by the Act are to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, hospitals and other medical institutions and agencies to achieve these ends by research, education and demonstrations of patient care. Through these means, the programs are intended to improve patient care for heart disease, cancer, stroke and related diseases, and to improve generally the health manpower and facilities of the nation.

In the two years since the President signed the Act, Regional Medical Programs have been organized in more than 50 regions which were defined by broadly representative groups. These regions encompass the nation's population. They have been formed by the organizing groups using functional as well as geographic criteria. These regions include combinations of entire states (such as the Washington-Alaska region), portions of several states (the Intermountain region includes Utah and sections of Colorado, Idaho, Montana, Nevada and Wyoming), single states (such as Georgia) and portions of states around a metropolitan center (the Rochester region includes the city and 11 surrounding counties). Within these Regional Programs, a wide variety of organization structures have been developed including executive and planning committees, categorical disease task forces and community and other types of subregional advisory committees.

The entire State of Florida became a region, and the Florida Advisory Council, Inc., (FAC) a corporation not for profit, was established (Table 1). The Council's board of directors is made up of representatives from the Florida Medical Association, the Florida Hospital Association, the three medical colleges, the boards of the three medical colleges, voluntary health agencies, the Florida State Board of Health and the citizens of the state. A planning grant was awarded to the Florida Regional Medical Programs in November of 1967 for $240,000 a year for two years. The Florida Medical Foundation of the Florida Medical Association is named as the fiscal agent, whose Board of Trustees volunteered to guarantee the fiscal stability and responsibility of FAC. The needs and problems identified in the



grant application were expressed as follows:

1. The Program will utilize and build upon existing institutions and manpower resources.
2. The active participation of practicing physicians is essential.
3. The purposes can best be achieved through initiative, planning and implementation at the community level under conditions which encourage innovative approaches and programs specifically designed to deal with the diversity

TABLE 1. — MEMBERSHIP, FLORIDA ADVISORY COUNCIL, INC.

Mr. Sam Blank
University of Miami Board of Trustees
Miami

Dr. Henry R. Cooper
Florida Heart Association
Ft. Lauderdale

Dr. Samuel M. Day
Florida Medical Association
Jacksonville

Dr. Sam Wesley Denham
Florida Division, American Cancer Society
Jacksonville

Dr. Richard M. Fleming
Florida Medical Association
Miami Beach

Mr. Henry D. Kramer
Board of Regents
Jacksonville

Dr. Alfred H. Lawton
University of South Florida
Tampa

Dr. Louis C. Murray
Board of Regents
Orlando

Dr. W. Dean Warren
University of Miami School of Medicine
Miami

Dr. William H. Proctor
Florida Medical Association
West Palm Beach

Dr. Wilson T. Sowder
Florida State Board of Health
Jacksonville

Dr. Emanuel Suter
University of Florida College of Medicine
Gainesville

Mr. Michael J. Wood
Florida Hospital Association
Jacksonville

Mr. W. Harold Parham
Florida Medical Foundation
Jacksonville

of needs, resources and existing patterns of education and service.

4. Cooperation among all essential elements of the health resources in a region is an essential means of coping with the complexities, specialization, high cost, manpower needs and educational and training needs which are the by-products of the dynamic advances of medical science.

5. In order to insure an effective linkage between research advances and improved patient care, continuing relationship among the research and teaching environment of the medical centers, the patient care activities involving the community hospital and practicing physicians must be developed.

6. The financing of patient care is not to be the objective of the Regional Medical Programs. The payment of patient care costs is limited to those costs incident to research, training and demonstration activities.

7. It is assumed that development of the full capabilities of a Regional Medical Program will take a number of years. The purpose of the first grant is to encourage and assist in the planning and implementation for the first steps

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

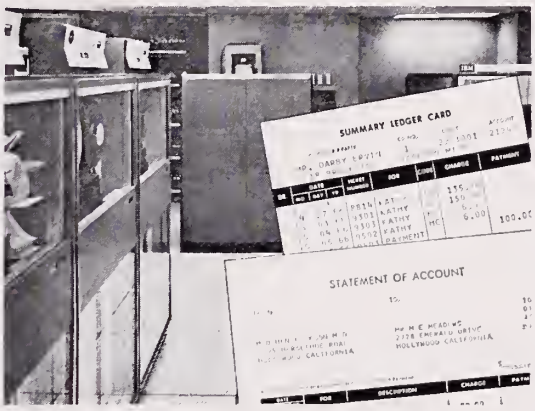
Lederle

330-8/6135

AUTOMATED MANAGEMENT SYSTEMS OF FLORIDA, INC.

First Federal Building
8340 N.E. 2nd Avenue
Miami, Florida 33138

Accounts receivable management system designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable maangement with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are a National Concern serving Doctors for over seven years.

☐ Please send me your Accounts Receivable Management Brochure.

☐ Please have one of your consultants call me for an appointment.

Name

Addresss

City Phone

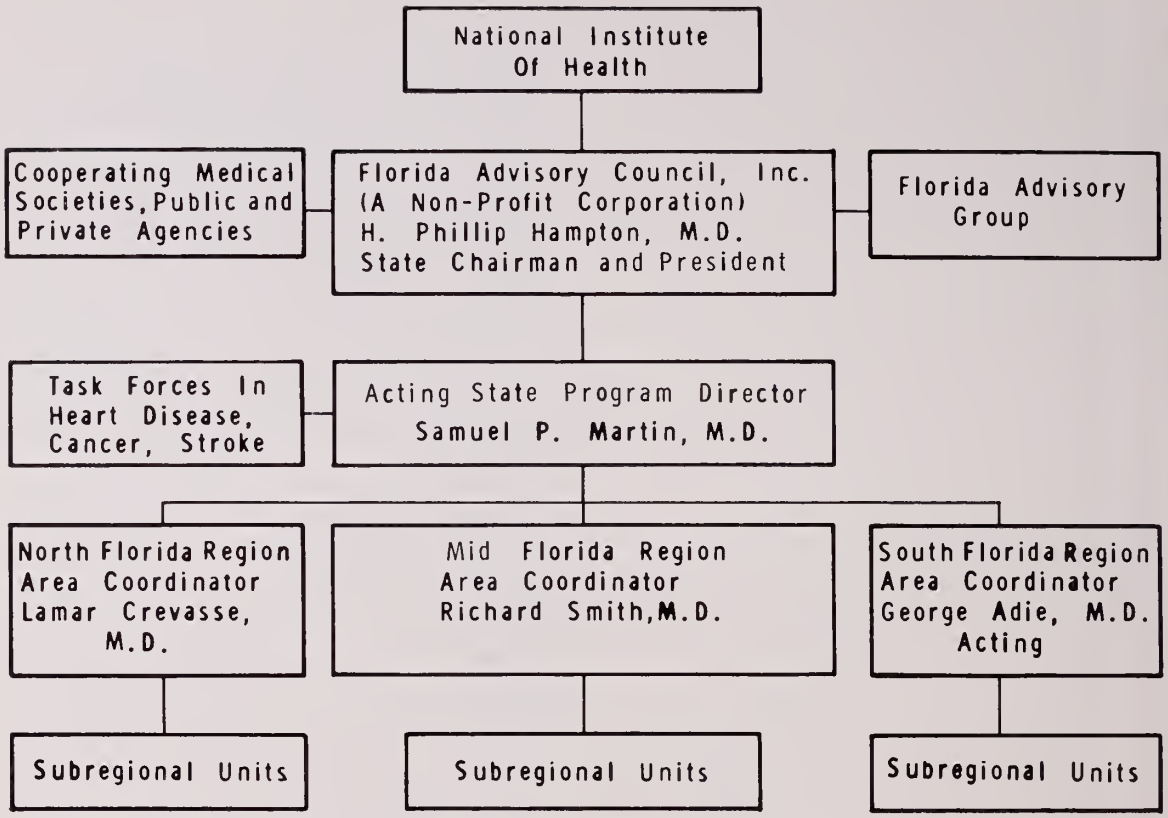


Fig. 1. — Regional medical program organizational chart.

toward the establishing of these local programs.

The organization of the program in Florida is shown in Figure 1. The state chairman, president of FAC, is Dr. H. Phillip Hampton. Acting program coordinator is Dr. Samuel P. Martin. Established under PL 89-239, the Florida Advisory Group (FAG) is representative of the professions and the people of Florida (Table 2). Operational grants must be approved by this group. For planning purposes the state will arbitrarily be divided into three areas centered around the medical schools within the state, and each area will have a coordinator. Areas will be comprised of subregional units centered around a hospital and staff or a consortium of hospitals and staffs. This unit will be the "work horse" of the program.

A number of local areas such as Jacksonville and Tampa already have developed local advisory groups and hospital consortiums which will provide the environment for education activities and demonstration projects. Dr. Lamar Crevasse has been appointed area coordinator for North Florida, Dr. George Adie as acting area coordinator in South Florida and Dr. Richard Smith is area coordinator for mid-Florida.

The Florida planning grant will determine our needs. It will provide for an inventory of resources such as manpower, facilities and existing programs. Studies will be conducted to divide the state into regions through determination of patient needs and lines of medical communication;a system to evaluate the effectiveness of the program will be developed.

Because of the broad latitude given to the community subregional units, it is difficult to identify what can or cannot be done by communities under this program. Among the broad range of elements which might be included in such plans are programs of continuing education, equipment and staff to enhance diagnostic and treatment capabilities and communication and computer systems for education and diagnosis.

Diversity of existing needs, resources, patterns of education and service in different areas of Florida call for a corresponding diversity of approaches to solve the health problems in each

Table 2. — Membership, Florida Advisory Group

Dr. Edmund Ackell
University of Florida College of Dentistry
Gainesville

Mr. Jacob F. Bryan III
Independent Life and Accident Insurance Company
Jacksonville

Mr. William E. Combs
Florida State Chamber of Commerce
Gainesville

Mr. Charles Cowl
State AFL-CIO
Tampa

Mr. Clifton Dyson
West Palm Beach

Mr. Wilmont Edwards
State Association of County Commissions
Panama City Beach

Mr. Robert L. Gilder
Employment Applications Orientation Project
Tampa

Mr. James Hammond
Commission of Community Relations
Tampa

Mrs. Wava D. Hartzel, R.N.
Ft. Lauderdale

Dr. Roger M. Hehn, D.D.S.
Jacksonville

Mr. Wright Hollingsworth
State Department of Public Welfare
Jacksonville

Mr. E. J. Johnston
Florida Crippled Children's Commission
Pensacola

Mr. Frank J. Kelley
The Florida Bar
Miami

Dr. Laurence C. Manni
State of Florida Department of Education
Division of Vocational Rehabilitation
Tallahassee

Dr. Darrel J. Mase
University of Florida College of Health Related Professions
Gainesville

Dr. Coyle E. Moore
Florida State University School of Social Welfare
Tallahassee

Mr. Malcom J. Randall
Veterans Memorial Hospital
Gainesville

Rev. B. F. Schumacher
Lutheran Senior Citizens Foundation, Inc.
Miami

William G. Page
Division of Community Hospitals and Medical Facilities
Florida Development Commission
Tallahassee

Dr. Morton Terry
Florida Osteopathic Medical Association
North Miami Beach

Mr. Gordon M. Wiggin
Florida Nursing Home Association
Ft. Lauderdale

Mr. Robert Roesch
Comprehensive Health Planning
Office of the Governor
Tallahassee

community. This underscores again the need for local initiative.

The fruits of the Regional Medical Program are already visible in a number of states where coronary care units, data banks and hospital information and teaching centers have been developed by local medical and health professional leadership.

On Nov. 9, 1967, the President sent the Congress the Report on Regional Medical Programs prepared by the Surgeon General of the Public Health Service and submitted to the President through the Secretary of Health, Education and Welfare in compliance with the Act. The report details the progress of Regional Medical Programs and recommends continuation of the programs beyond the June 30, 1968 limit set forth in the Act. The President's letter transmitting the Report to the Congress was at once encouraging and exhortative when it said, in part: "Because the law and the idea behind it are new, and the problem is so vast, the program is just emerging from the planning state. But this report gives encouraging evidence of progress—and it promises great advances in speeding research knowledge to the patient's bedside." Thus in the final seven words of the President's message, the objective of Regional Medical Programs is clearly emphasized.

▶ Dr. Hampton, One Davis Boulevard, Tampa 33606.

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

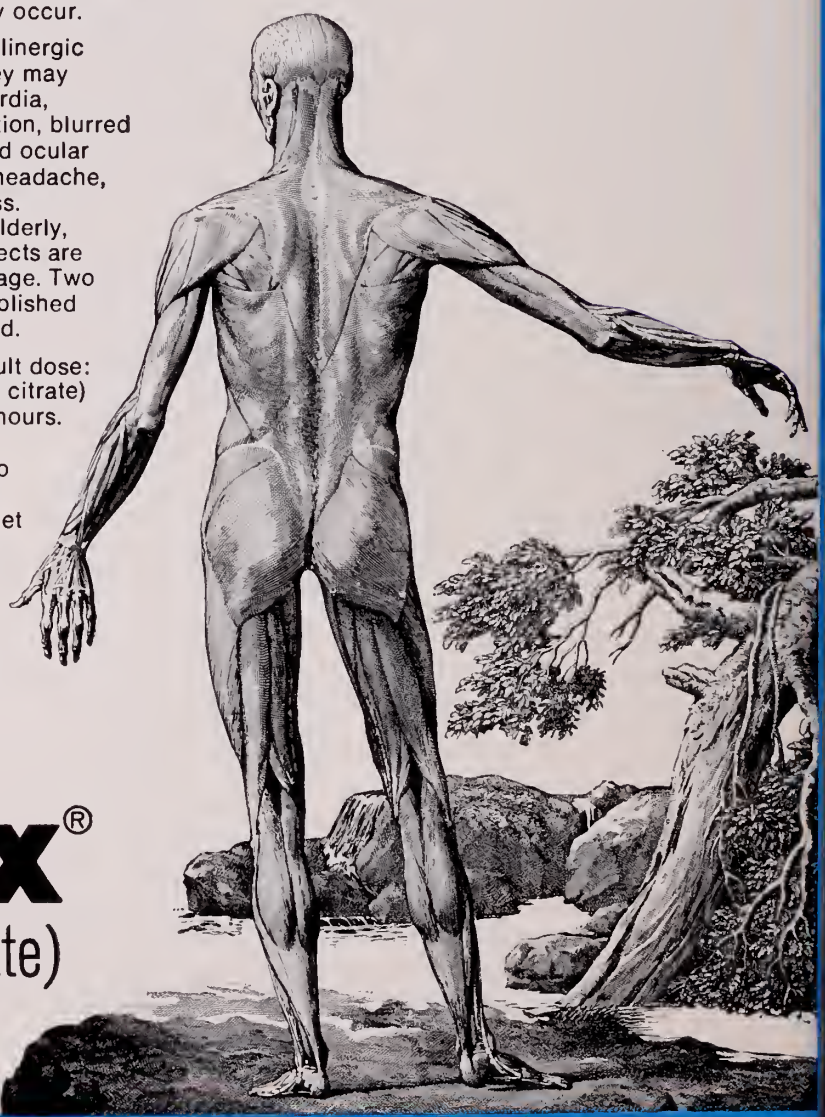
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

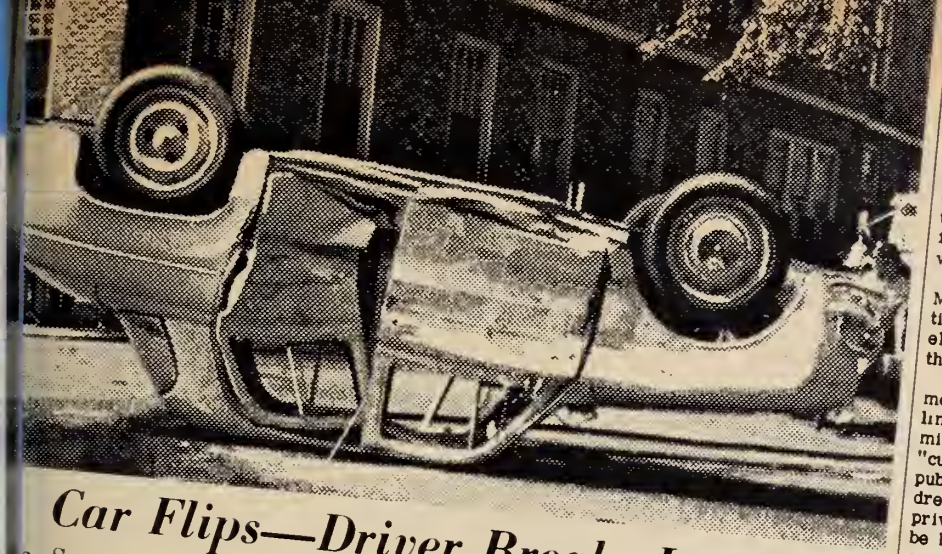
DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)



STAFF PHOTO

Car Flips—Driver Breaks Leg

s, Sept. 7. John P. Jones of
incurred a broken leg today
driving

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its top
Hasn't he

tion in rec
For se
board h
statemer
issue, a
tember th
fications'
ton dicta
Althou
made Mo
down by a
ter shar
flat obje
was passe
Board
McCredi
tion" s
elimir
the st
The c
ment ca
limit ra
mile li
"cut-of
public
dren
priv
be b
or th
schoo
The
so soi
rather
burs

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

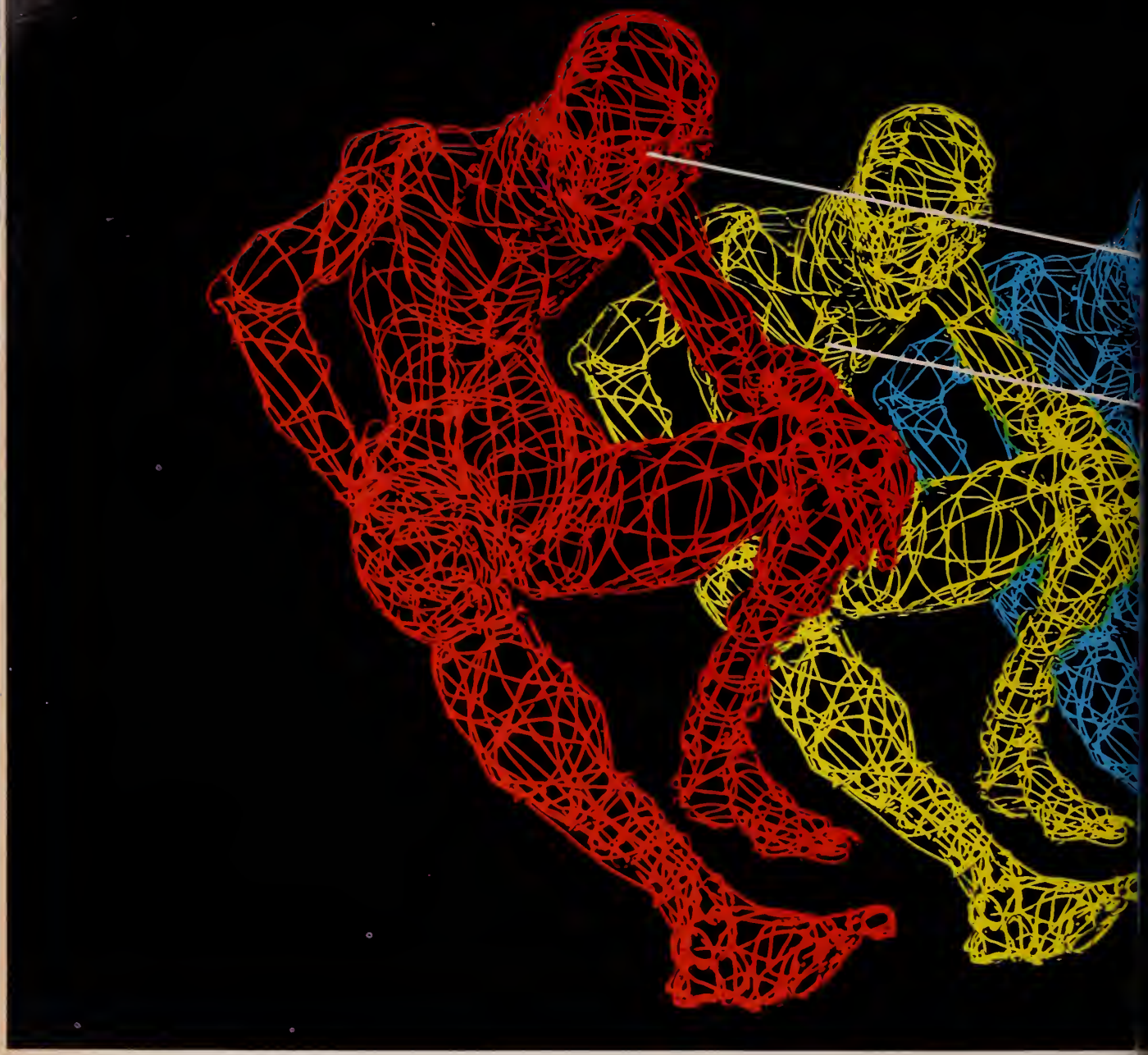
THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

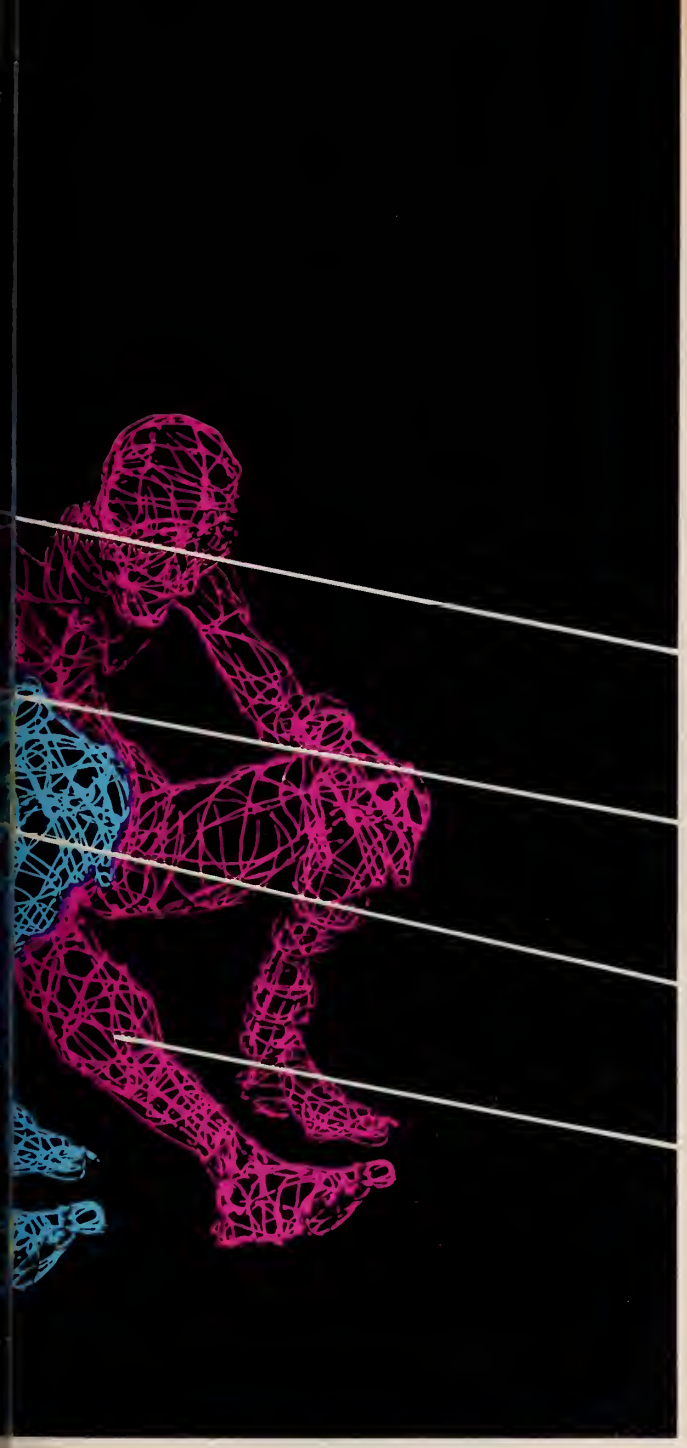
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potential action of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed during follow-up is the final criterion for adequacy of therapy. Perni-



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Florida Medical | medicolegal

Scared to Death

Donald L. Howie, M.D.

Death due to fright apparently does occur. This is true even in areas where voodoo and witchcraft do not hold sway. The significance of fright is ignored in the majority of cases where anatomical causes of death are evident. Thus, we seldom pay attention to the significance of fright in drownings. This is true despite the fact that the common Red Cross literature says "Don't panic." The person who "freezes" in an intersection and is hit by a car might have lived but for fright.

Fright, of course, can kill in other ways than by producing inability to act or function rationally.

A few months ago an elderly man was shopping at a local department store. He had picked up many items, the most expensive probably valued at no more than $2.00. Either through intent or forgetfulness, the gentleman neglected to pay for his purchases. The alert assistant manager noticed this crime in the making, walked up to the man and took hold of his arm, apparently without undue violence. The man slumped to the floor pulseless and never recovered.

At autopsy, results of the blood alcohol test were negative and there was no reason to suspect that the man was on any unusual drugs. The 390 Gm. heart showed an old posterior left ventricular infarct and a rather large old apical infarct. The right coronary artery was completely occluded 3 cm. from its origin and the left coronary ostium was more than 50% reduced in diameter. Vascular disease also had produced a considerable degree of cerebral atrophy but had not significantly altered the kidney architecture. He had pulmonary emphysema and fibrosis.

Upon microscopic examination the heart was found to have, in the area of the largest old infarction, multiple medium-sized fresh periventricular hemorrhages and marked passive congestion of all organs.

Another somewhat similar case was autopsied by Dr. Robert W. Huntington Jr. in California. During an ordinary business day in a downtown section, a woman was walking along the street apparently shopping. She was about 30 years of age. Suddenly an earthquake of considerable force began. This cracked some buildings and dropped concrete, bricks and miscellaneous debris to the street. According to witnesses, the woman was never struck by any of the debris. She immediately collapsed and was dead by the time anyone could examine her. Careful examination showed no injuries. Results of the autopsy showed a lack of any antecedent disease process which would have made this woman prone to such a death.

In the first case, we have a gentleman who was a perfect target for a neurogenic arrhythmia with considerable sickness of both brain and heart. Although there was reason to believe that he was an experienced shoplifter, we know of no record of his having been previously apprehended for

A continuing series prepared by members of the Florida Society of Pathologists.

A Modern Psychiatric Hospital . . .



This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

Member American Hospital Association
Medicare Provider

such a crime. We have no evidence that he was ever given cardiac massage and the fresh perivascular hemorrhages in one of the old infarcts apparently were a part of his terminal episode. In the second case, that of the young woman without anatomical antecedents, there was no way in which we could rule out the possibility that she was previously afflicted by a bundle branch block or other cardiac electrical disturbance. It could be argued, of course, that she was really not frightened and that whatever caused her collapse and demise was purely coincidental.

The fact remains, however, that fright, fear and superstition are concomitant to a certain number of deaths. Perhaps in these individuals, as in suicides, we might do well to conduct "psychological autopsies," for it is most difficult to identify fright anatomically.

▶ Dr. Howie, Mound Park Hospital, St. Petersburg 33731.

New Clinical Laboratory Law

Nathan J. Schneider, Ph.D., M.P.H., Director, Bureau of Laboratories, Florida State Board of Health, has written to suggest that physicians may be interested in reading this message from him.—Ed.

Clinical laboratories operated by and performing work for six or more physicians practicing together and doing laboratory work on their collective patients are required to register under and comply with the provisions of the new Florida Clinical Laboratory Law, Chapter 483, Florida Statutes, as registered with the Secretary of State on June 28, 1968.

The new law states ". . . those clinical laboratories exempted shall be limited to those operated by and performing clinical laboratory work for no more than five licensed practitioners of the healing arts, practicing together and doing laboratory work on their collective patients."

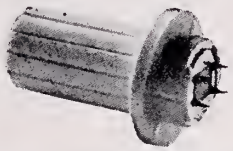
All clinical laboratory personnel employed in laboratories operated by and performing work for six or more physicians must be licensed under the new law. The law does not require a license for or payment of a fee by the physician if said physician is licensed to practice in Florida.

Registration and licensure applications, as well as further information, may be obtained by writing the Florida State Board of Health, Bureau of Laboratories, P. O. Box 210, Jacksonville 32201.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

A COMPLETE BUSINESS SERVICE

Professional Management

FOR THE MEDICAL
AND DENTAL
PROFESSIONS

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS since 1932 PM ©

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

St. Francis Hospital
Third Annual Medical-Surgical Seminar

Hospital Auditorium
Miami Beach, Fla.

Wednesday and Thursday
October 23-24, 1968

"Practical Aspects Of Pulmonary Diseases"

Maurice Segal, M.D., Director of Lung Station, Tufts University

1. Management of Patient with Acute Respiratory Insufficiency
2. Bronchial Asthma, Chronic, Acute Recent Management and Therapy

Edward A. Gaensler, M.D., Professor of Surgery, Boston University School of Medicine

1. Selection of Emphysema Patients for Surgery
2. Mechanics of Breathing, Normal and Abnormal

Asher Marks, M.D., Associate Professor of Medicine, University of Miami School of Medicine

1. The Many Faces of Sarcoid

Marvin Sackner, M.D., Chief, Division of Pulmonary Diseases, Mt. Sinai Hospital, Miami Beach, Florida

1. Interpretation of Arterial Blood Gas Analysis

Panels

1. The Management of Patient with Chronic Respiratory Disease
2. Management of "Status Asthmaticus"
3. Surgical and Medical Advances in Diagnosis and Therapy of Pulmonary Neoplasm

Approved for 8½ elective hours AAGP

Sessions

Wednesday and Thursday
October 23-24, 1968—2-5 & 8-10 P.M.

For additional information: Contact Seminar Office, St. Francis Hospital, Miami Beach, Florida

Telephone: 866-7741

No registration fee.

Easy on the Budget...
Easy on the Mother
Tablets & Elixir
For Iron Deficiency Anemia

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

FAMOUS Fergon®
brand of FERROUS GLUCONATE

TUCKER HOSPITAL, INC.

212 West Franklin Street
Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

Florida Medical meetings

FMA Approved Postgraduate Meetings

SEPTEMBER
13-14 Seventh Annual Physicians' Seminar on Respiratory Diseases, Hotel Robert Meyer, Jacksonville
20-21 Cardiovascular Disease Seminar, International Inn, Tampa

OCTOBER
4- 5 Otolaryngology Seminar, J. Hillis Miller Health Center, Gainesville
10-12 Pediatric-Cardiology Seminar, J. Hillis Miller Health Center, Gainesville
14-18 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach (Approved 12½ hours accreditation AAGP)
18-19 Florida Industrial Medical Association's Second Industrial Health Conference, Sheraton Motor Inn, Tampa
24-25 Seminar on Obstetrics and Gynecology, J. Hillis Miller Health Center, Gainesville

NOVEMBER
1- 2 Athletic Injuries Seminar, J. Hillis Miller Health Center, Gainesville
7- 9 Today's Hospital Problems: Second Annual Conference, University of Florida and Mound Park Hospital Foundation, Tides Hotel and Bath Club, Redington Beach.

JANUARY
9-12 Sixth Annual Postgraduate Seminar in Anesthesiology, Eden Roc Hotel, Miami Beach
15-18 Seminar in Surgery Art and Science in Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach
26-30 Annual Pediatric Postgraduate Course—"Renal and Genitourinary Disorders," Deauville Hotel, Miami Beach

National and Regional Meetings in Florida

SEPTEMBER
27-28 American College of Physicians Southeastern regional scientific meeting for specialists in internal medicine, Happy Dolphin Inn, St. Petersburg

OCTOBER
11-19 Society of Clinical Pathologists, Fontainebleau Hotel, Miami Beach
12-18 College of American Pathologists, Fontainebleau Hotel, Miami Beach

NOVEMBER
19-20 Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour
21-26 American Heart Association, Americana Hotel, Bal Harbour

DECEMBER
1- 4 Clinical Convention of the American Medical Association, Miami Beach
4- 6 Academy of Psychosomatic Medicine, Eden Roc Hotel, Miami Beach
7 South Florida Psychiatric Society, University of Miami School of Medicine, Miami
9-11 Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton
10-14 American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour

FEBRUARY
13-15 Society of University Surgeons, Fontainebleau Hotel, Miami Beach

MARCH
2- 5 International Anesthesia Research Society, Americana Hotel, Bal Harbour
15-19 American Academy of Allergy, Americana Hotel, Bal Harbour

APRIL
28-May 1 American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour
30-May 3 Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne

MAY
2- 4 American Academy of Psychoanalysis, Deauville Hotel, Bal Harbour
3 American College of Psychiatrists, Deauville Hotel, Bal Harbour
4- 9 American Society for Microbiology, Fontainebleau Hotel, Miami Beach
5- 9 American Psychiatric Association, Americana Hotel, Bal Harbour
22-25 National Tuberculosis and Respiratory Diseases, Fontainebleau Hotel, Miami Beach
24-26 American Thoracic Society, Fontainebleau Hotel, Miami Beach



*"Now that your acne is clearing up nicely,
it might be a good idea if you started losing some weight."*

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

Thomas B. Slade **Fifty Years in Florida** **J. Beatty Williams**

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 **P. O. Box 2580 — 1050 W. Adams Street** **Jacksonville, Fla. 32203**



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request
Member NAPPH, American Psychiatric Assn., & American Hospital Assn.



the spasm reactors your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
cyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
pine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
cine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
obarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

rning: may be habit forming)

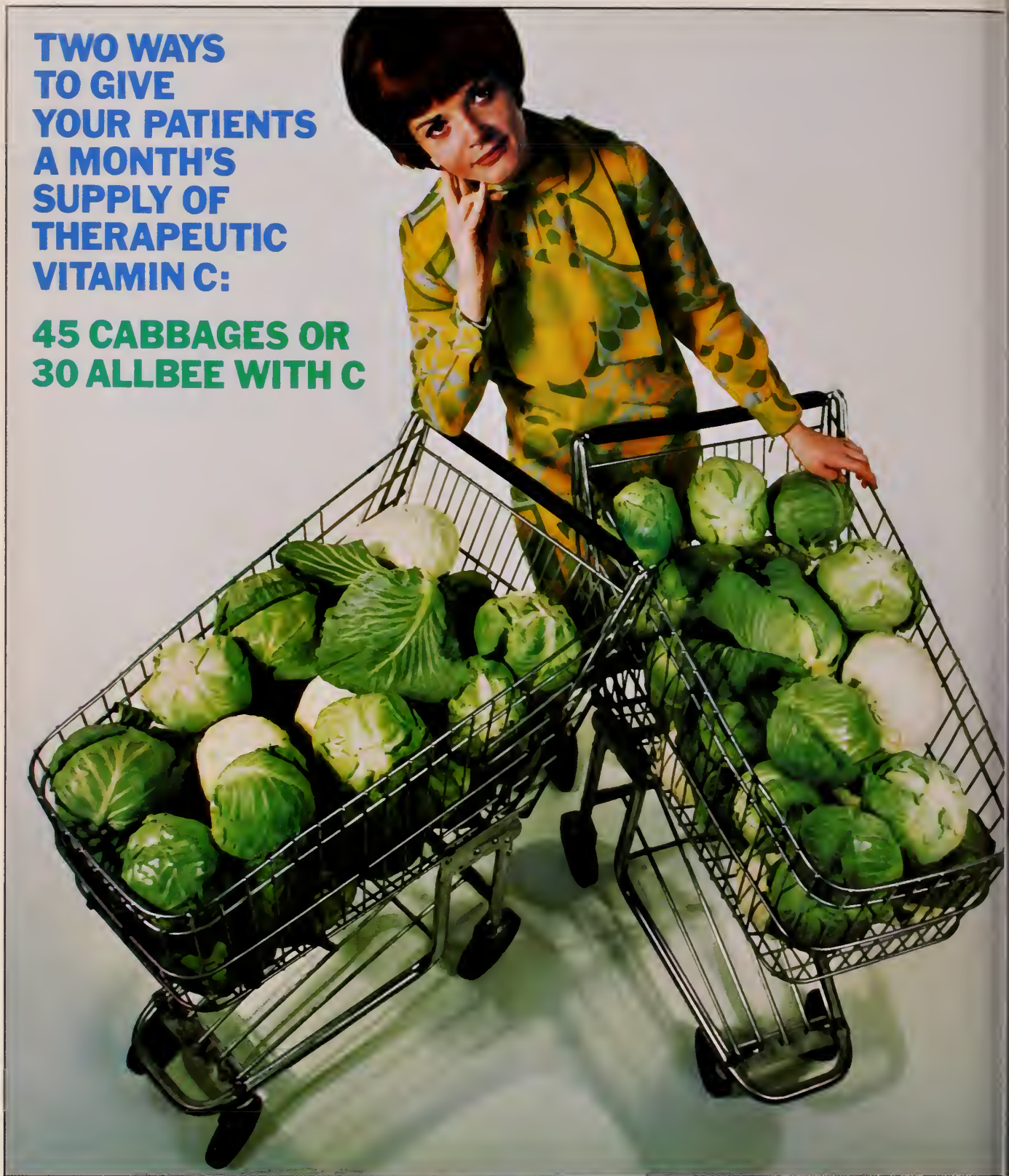
A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A·H·ROBINS

TWO WAYS TO GIVE YOUR PATIENTS A MONTH'S SUPPLY OF THERAPEUTIC VITAMIN C:

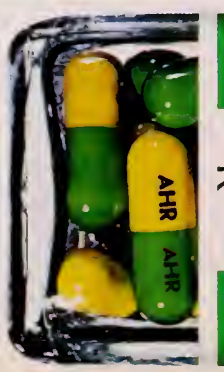
45 CABBAGES OR 30 ALLBEE WITH C



Your patient would have to eat 45 cabbages a month (1-1/2 a day) to get as much vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak.

Write "30" for B and C deficiencies. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220.



A·H·ROBINS

30 Capsules
Allbee® with C

Each capsule Contains:

Thiamine mononitrate (Vit. B_1)	15 mg
Riboflavin (Vit. B_2)	10 mg
Pyridoxine hydrochloride (Vit. B_6)	5 mg
Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg



Florida Medical deaths

Brown, Edgar Ferdinand, Lake City; born 1875; University of Louisville School of Medicine, 1897; life member FMA; died Dec. 16, 1967, aged 91.

Born, Charles Allen, Pensacola; born Aug. 10, 1903, Pensacola; Tulane University School of Medicine, 1929; life member FMA; member AMA; died Dec. 24, 1967, aged 64.

Burgner, Blanche Amelia, Sarasota; born Apr. 18, 1874, Chicago, Ill.; Chicago College of Medicine and Surgery, 1910; life member FMA; member AMA; died Jan. 5, 1968, aged 94.

Cason, Turner Zeigler, Jacksonville; born Oct. 11, 1886, Gainesville; Medical College of Georgia, 1913; life member FMA; member AMA; died Jan. 24, 1968, aged 82.

Corbitt, Jack, Panama City; born June 16, 1918, Hartford, Ala.; Tulane University School of Medicine, 1944; member AMA; died Oct. 16, 1967, aged 49.

Dunham, Charles Thomas, St. Petersburg; born July 7, 1915, Racine, Wis.; Marquette University School of Medicine, 1950; member AMA; died Jan. 12, 1968, aged 53.

Glennan, Thomas Luke, Green Cove Springs; born Feb. 11, 1910, Little Rock, Ark.; Medical College of South Carolina, 1933; member AMA; died Oct. 22, 1967, aged 57.

Garrard, Hollis Franklin, Miami; born Aug. 18, 1910, Birmingham, Ala.; Rush Medical College, 1933; member AMA; died Jan. 14, 1968, aged 58.

Johnson, Marion Franklin, Fort Myers; born Nov. 23, 1886, Midland City, Ala.; Tulane University School of Medicine, 1909; member AMA; died Jan. 29, 1968, aged 82.

Kennedy, Alpheus Thomas, Pensacola; born March 8, 1921, Lakeland; Emory University School of Medicine, 1944; member AMA; S. E. Surg. Cong.; died Dec. 2, 1967, aged 47.

Martin, J. William, Orlando; born Oct 30, 1880, Martinsburg, Mo.; Barnes Medical College, 1912; life member FMA; died Dec. 21, 1967, aged 87.

McKibben, William Watson, Miami; born Aug. 22, 1872, Fort Smith, Ark.; Harvard Medical School, 1900; life member FMA; member AMA; died Jan. 12, 1968, aged 96.

Pearson, Rufus Judson Sr., Bay Pines; born Jan. 24, 1881, Richland, Ga.; Emory University School of Medicine, 1915; died Jan. 26, 1968, aged 89.

Ruskin, Joseph J., Tampa; born Jan. 15, 1904, Newport, Pa.; St. Louis College of Physicians and Surgeons, 1935; member AMA; died Dec. 24, 1967, aged 63.

vonColditz, Grambow Thomsen, Merritt Island; born Oct. 21, 1877, Chicago, Ill.; Loyola University School of Medicine, 1902; member AMA; died Oct. 23, 1967, aged 91.

Wallace, Arthur Jamison Jr., Tampa; born Nov 1, 1916, Birmingham, Ala.; Tulane University School of Medicine, 1941; member AMA; died Nov. 15, 1967, aged 51.

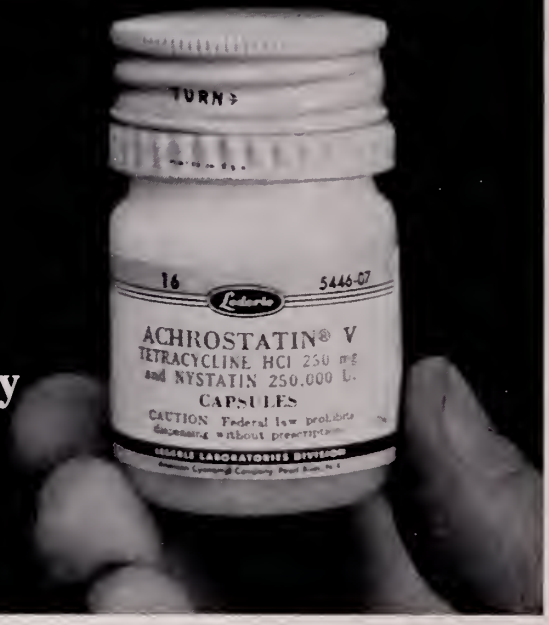
Williams, John L., Tallahassee; born 1901; Emory University School of Medicine, 1928; life member FMA; died Dec. 30, 1967, aged 66.

Wimbish, Ralph M., St. Petersburg; born July 24, 1922, Cordele, Ga.; Meharry Medical College, 1950; died Dec. 12, 1967, aged 45.

The lowest priced tetracycline-nystatin combination

ACHROSTATIN® V Capsules

Tetracycline HCl 250 mg /Nystatin 250,000 units



One of the 31 useful dosage forms in the ACHRO Family -the First Family of Tetracycline

Lederle

328-8/6094

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



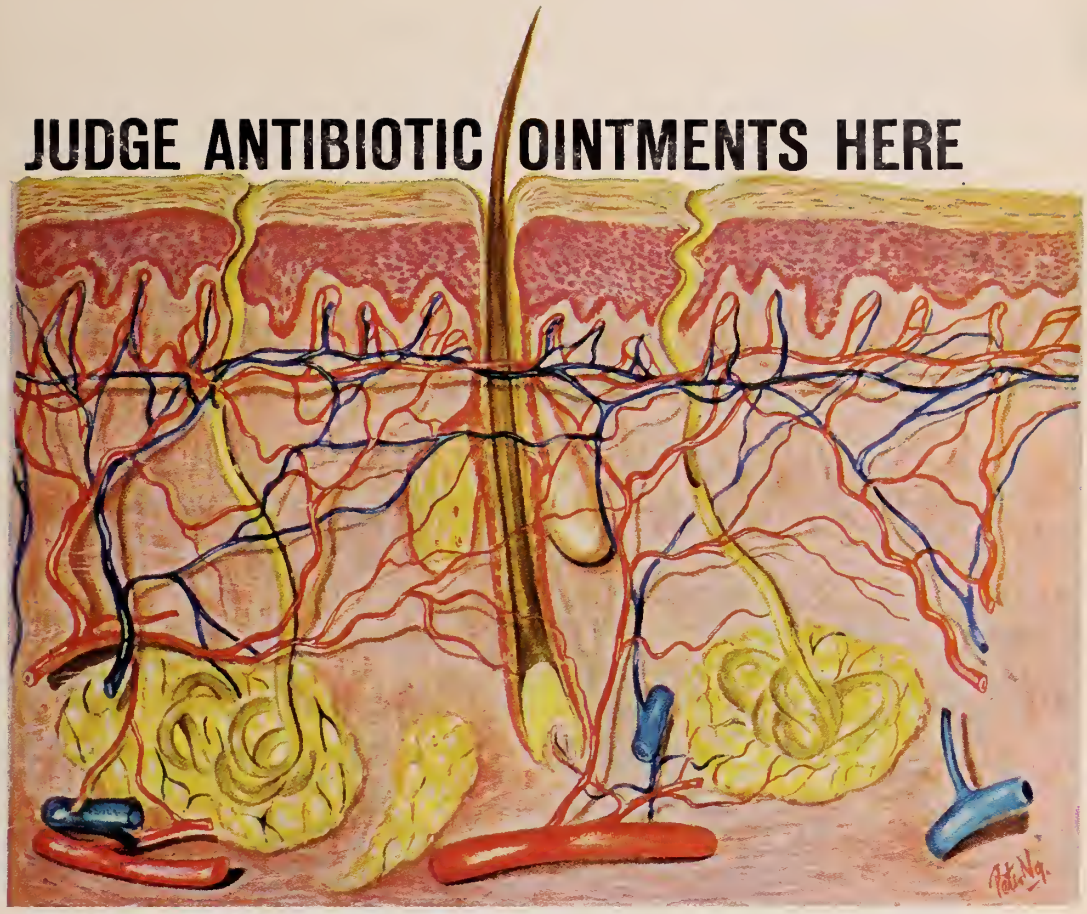
MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . .
. . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . .
ALABAMA HOSPITAL ASSOCIATION . . .
BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest HOSPITAL
BIRMINGHAM, ALABAMA

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.


Muscle in Spasm

and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets



Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Louie lost weeks with
a painful shoulder. That's a lot of fish.
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

If it doesn't work in a week, forget it

t please don't forget this:

ontraindications: Edema; danger of cardiac compensation; history or symptoms of peptic cer; renal, hepatic or cardiac damage; tory of drug allergy; history of blood dys- asia. The drug should not be given when the tient is senile or when other potent drugs are ven concurrently. Large doses of the alka rmulation are contraindicated in glaucoma.

arning: If coumarin-type anticoagulants are ven simultaneously, watch for excessive crease in prothrombin time. Instances of vere bleeding have occurred. Persistent or vere dyspepsia may indicate peptic ulcer; rform upper gastrointestinal x-ray diagnostic sts if drug is continued. Pyrazole compounds ay potentiate the pharmacologic action of lfonylurea, sulfonamide-type agents and sulin. Carefully observe patients receiving ch therapy. Use with caution in the first tri- ester of pregnancy and in patients with yroid disease.

ecautions: Before prescribing, carefully lect patients, avoiding those responsive to utine measures as well as contraindicated tients. Obtain a detailed history and a com- ete physical and laboratory examination, cluding a blood count. The patient should not ceed recommended dosage, should be osely supervised and should be warned to scontinue the drug and report immediately fever, sore throat, or mouth lesions (symp- ms of blood dyscrasia); sudden weight gain ater retention); skin reactions; black or tarry ools or other evidence of intestinal hemor- age occur. Make complete blood counts at eekly intervals during early therapy and at week intervals thereafter. Discontinue the ug immediately and institute counter- easures if the white count changes signifi- antly, granulocytes decrease, or immature rms appear. Use greater care in the elderly nd in hypertensives.

dverse Reactions: The more common are ausea and edema. Swelling of the ankles or ce may be minimized by withholding dietary lt, reduction in dosage or use of diuretics. In derly patients and in those with hypertension e drug should be discontinued with the ppearance of edema. The drug has been ssociated with peptic ulcer and may reac- vate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)R 46-070-A

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

BU-5926

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: GP (AAGP) to join established GP in rapidly growing community. New 200 bed hospital. Write C-816, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Physician to do general practice with two established G.P.s for association and eventual partnership. 35 bed approved JCAH hospital soon to expand—with modern Professional Arts Bldg. and Northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER with Florida license wanted in Orlando area. Full time opening in county supported outpatient medical clinic. Regular hours, no nights or weekends. Starting salary $18,000; social security, paid insurance, retirement, other fringe benefits. Contact Victoria B. Vacha, M.D., 89 West Copeland Drive, Orlando 32806. Telephone (305) 241-4311, ext. 368.

GENERAL PRACTITIONER for long established group, Hollywood, Florida. Must have Florida license and completed military obligation. Excellent opportunity for an energetic and capable individual. Salary open. Write John Kerwick, Manager, Box 2308, Hollywood, Fla. 33022.

WANTED: General practitioner for association with mixed group. Salary plus percentage and all expenses. Share coverage on day off, weekends, vacations. Guarantee $20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305) 636-4221.

Specialists

OBSTETRICIAN-GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla. 33153.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

PEDIATRICIAN WANTED: Board certified or board qualified to associate with established two man practice in southeast area. Population 100,000. Excellent salary with full partnership in mind. Write C-847, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Compensation open. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

INTERNIST WANTED: To associate with established internist in greater Miami area. Terms open. Attractive fringe benefits. Large, active practice. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified to associate with two physicians in the greater Miami area. Salary open. Write C-845, P. O. Box 2411, Jacksonville, Fla. 32203.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd., W., Bradenton, Fla. 33505.

WANTED: Internal medicine practice opportunity for board eligible internist with subspecialty interest in Southeastern coastal community. Starting salary $21,000 first year with opportunity for full partnership. Write C-844, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Partnership-internist to head department of large established Lauderdale practice. Excellent facilities, new building with unusual ancillary services. Write C-848, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST OR CARDIOLOGIST WANTED IMMEDIATELY to join well established group on Miami Beach. Excellent starting salary and full partnership offered. Contact Nathan N. Kimball, M.D., Professional Associates, 333 Arthur Godfrey Rd., Miami Beach, Fla. 33140. Phone 531-6755.

PEDIATRICIAN: Board certified or eligible for long established group, Hollywood, Florida. Must have Florida license and completed military obligation. Excellent opportunity for an energetic and capable individual. Salary open. Write John Kerwick, Manager, Box 2308, Hollywood, Fla. 33022.

Miscellaneous

INTERNIST OR GP: North Miami Beach, Fla. $18,000 start—leads to association. Contact Mr. Harold Kwart, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GP OR INTERNIST to associate with three man group, one surgeon and two GP's. Suburban Jacksonville. 30,000 first year to approximately $40,000 in two years of partnership as agreed. Call Dr. M. B. Bergh, (904) 264-9511.

WANTED: GP or General Surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

MEDICAL DIRECTOR WANTED: For large industrial plant. Background of industrial medicine, internal medicine or general practitioner acceptable. Medical department includes modern first aid facilities and 24 hour RN coverage. Excellent benefits. Salary open. An equal opportunity employer. Contact Personnel Manager, St. Regis Paper Company, P.O. Box 1591, Pensacola, Fla. 32502.

WANTED: Emergency room physician in hospital; to join group of private physicians, 42 hour week, income $20,000 plus. Contact Bruce S. Webster, M.D., 89 W. Copeland Dr., Orlando, Fla. 32806. Phone 241-4311, Ext. 380 or 647-5728.

situations wanted

ORTHOPEDIC SURGEON: Age 40, board certified, F.A.C.S., Florida license, eight years busy private Midwest practice, wishes to practice in Florida. Partnership in college town preferred. Write C-825, P.O. Box 2411, Jacksonville, Fla. 32203.

POSITION WANTED: Indiana University (AOA) radiology resident, age 30, military service completed, seeks radiology group position for July 1969. Have Florida license. Write C-846, P.O. Box 2411, Jacksonville, Fla. 32203.

PATHOLOGIST, CP and PA certified, 14 years department director 300 bed hospital. Director school medical technology. Radioisotopes licenses. Teaching challenge welcomed. Desire relocation South Florida (licensed). Available immediately. Write C-835, P. O. Box 2411, Jacksonville, Fla. 32203.

practices for sale

FOR SALE OR LEASE: Active practice 21 years. Spacious 12 room modernly equipped establishment, new 62 bed hospital in Sebring, Fla. Contact Stanley K. Wallace, M.D., 32 N. Commerce St., Sebring, Fla. 33870. Telephone 385-8640.

FOR SALE: Active general medical practice along with beautiful modern three bedroom, fully air-conditioned, brick home including office and parking on spacious landscaped grounds in Dunedin. Separate 3 car garage with two bedroom apartment above. Near good hospital. Reason for selling—retirement. Inspection invited. Telephone (813) 733-7850.

real estate

FOR RENT: Medical office complete. New. Rent free to December 1968. Write Suite 111, 4800 N.E. 20th Terrace, Fort Lauderdale, Fla. 33301.

MEDICAL OFFICE FOR RENT: Excellent opportunity. Physician leaving area. 3 treatment rooms, darkroom, lab, carpeted private office, etc. Rental only $210 monthly. St. Petersburg, Florida 33703. Phone 526-3868.

NEW MEDICAL OFFICE: Available Nov. 1, 1968. 2,000 sq. ft., Deerfield Beach, Fla. One half block from U.S. Highway 1. Bank, savings loan, shopping center across street. Central air, 500 apartments within 3 blocks, elevator. $3. sq. ft. to your specification. Louis Spirrison, 1043 Hillsboro, Pompano Beach, Fla. 33062. (Phone) 941-4036.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Florida Medical Association Officers and Council Chairmen

Officers

Jack Q. Cleveland, M.D., Coral Gables, President
Henry J. Babers Jr., M.D., Gainesville, President-Elect
Irving E. Hall Jr., M.D., Bradenton, Vice President
James T. Cook, M.D., Marianna, Speaker of the House
Charles K. Donegan, M.D., St. Petersburg, Vice Speaker
Floyd K. Hurt, M.D., Jacksonville, Secretary-Treasurer
W. Dean Steward, M.D., Orlando, Immediate Past President
W. Harold Parham, Jacksonville, Executive Director

Chairmen

James W. Walker, M.D., Jacksonville, Allied Professions and Vocations
John J. Cheleden, M.D., Daytona Beach, Judicial
Jere W. Annis, M.D., Lakeland, Legislation and Public Agencies
Jack A. MaCris, M.D., St. Petersburg, Medical Economics
James M. Ingram, M.D., Tampa, Medical Services
Richard C. Dever, M.D., Miami, Scientific Activities
William C. Roberts, M.D., Panama City, Special Activities
Joseph G. Matthews, M.D., Orlando, Specialty Medicine
Hawley H. Seiler, M.D., Tampa, Voluntary Health Agencies

Highland Hospital

Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

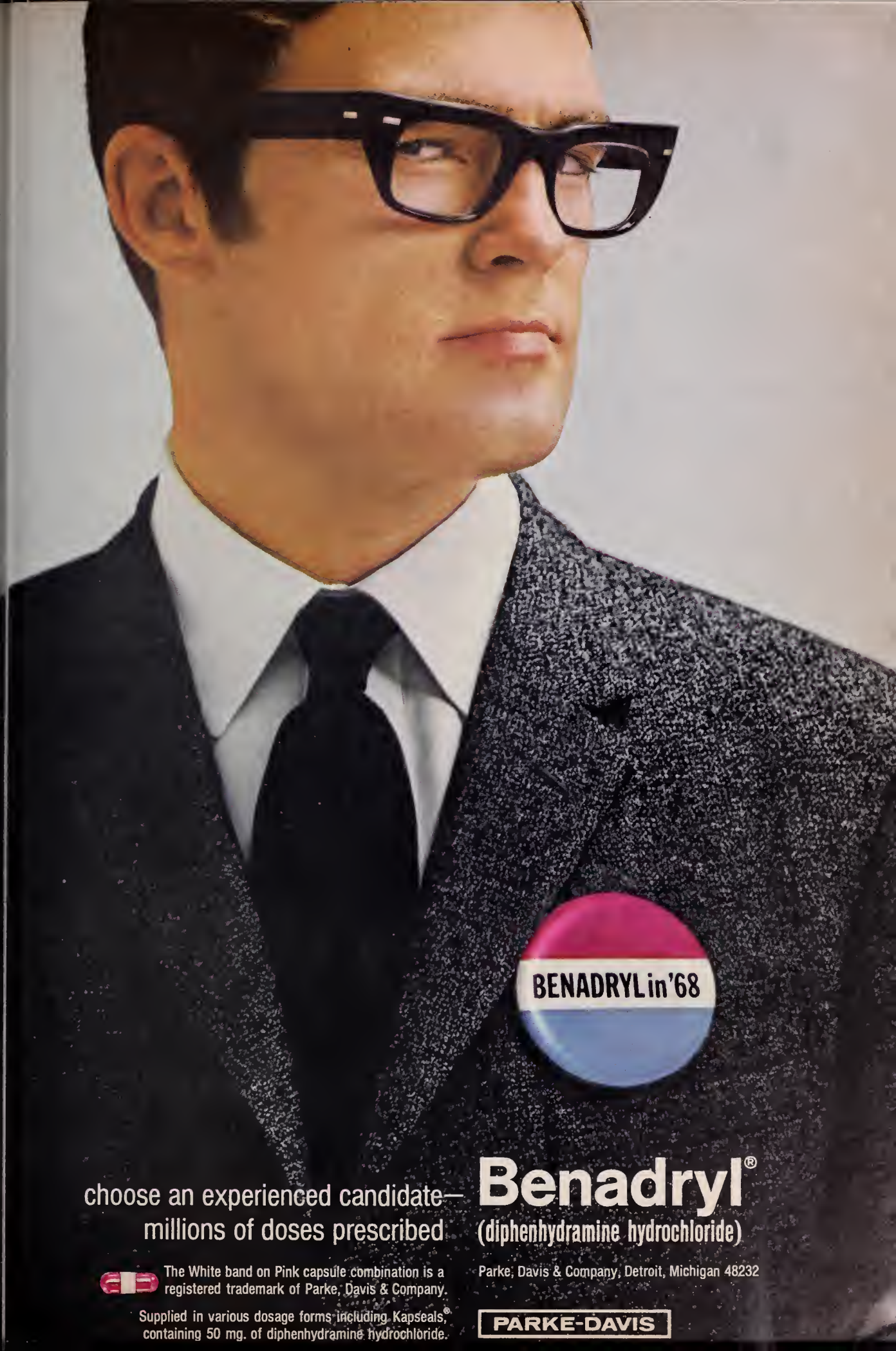
Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761



choose an experienced candidate—
millions of doses prescribed

Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8

Florida Medical advertisers

Abbott Laboratories
Enduron 844a
Enduronyl 844a
Eutron 844a, 845

Anderson Surgical Supply Co. 868

Automated Management 857

Ayerst Laboratories
Mediatric 808-809

Bradley Center 838

Breon Laboratories
Fergon 864

Bristol Laboratories
Tetrex F 804

Burroughs-Wellome Co.
Neosporin 870a

Campbell Soups 836a

Convention Press 841

Dow Chemical Company
A & I Bioproducts 802

Eaton Laboratories
Furacin 813

Geigy Pharmaceuticals
Butazolidin 870a, 871
Tandearil 846-847

Guild of Prescription Opticians 844

Highland Hospital, Inc. 874

Hill Crest Hospital 870

Hynson, Westcott & Dunning, Inc.
Lutrexin 799

Lakeland Manor 862

Lakeside Laboratories
Imferon 853

Lederle Laboratories
Achromycin 874a
Achrocidin 804a
Achrostatin 870
Bamadex 866-867
Declomycin 801
Histoplasmin Tine Test 863
Peritinic 851
Tuberculin Tine Test 857

Eli Lilly & Co.
Keflin 836a
Trinsicon 860a
V-Cillin K 814

Medical Supply Co. 850

Merck, Sharp & Dohme
Elavil 798
Hydropres 810-812

National Drug Co.
Quinamm 841

Parke-Davis & Co.
Benadryl 804a

Pitman-Moore
Novahistine 806

P. L. Dodge Memorial Hospital 868

PM of Florida 863

William P. Poythress & Co.
Trocinate 849

Riker Laboratories
Norflex 860

A. H. Robins, Inc.
Allbee 868a
Donnatal 868a
Phenaphen 860a
Robinul Forte 842-843
Robitussin 850

Roche Laboratories
Librium ..... Back Cover
NCME-TV 854
Valium 870a

J. B. Roerig Co.
Tao 852a

Wm. H. Rorer, Inc.
Emetrol 838
Parepectolin 852

St. Francis Hospital 863

Sandoz
Mellaril 852a

G. D. Searle Co.
Pro Banthine 836a

Smith, Kline & French Laboratories
Thorazine 837

Strasenburgh Laboratories
Omni-Tuss 852a

Stuart Co.
Mylanta 860a

Surgical Supply Co. 868

Tucker Hospital, Inc. 864

S. J. Tutag
Cydril 856

Warner Chilcott Laboratories
Sinutab 802a

Wyeth Laboratories
Pen Vee K 803
Tubex 812a

Whenever anxiety induces or intensifies clinical symptoms

LIBRARY
SE... ...
OF MEDI...

Librium®

(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination,on proper dosage~Has wide margin of safety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche®
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

NY ACADEMY MED LIBRARY
2 EAST 103RD ST
NEW YORK NY 10029

boxide) 5-mg, 10-mg, 25-mg tablets

BALCONY

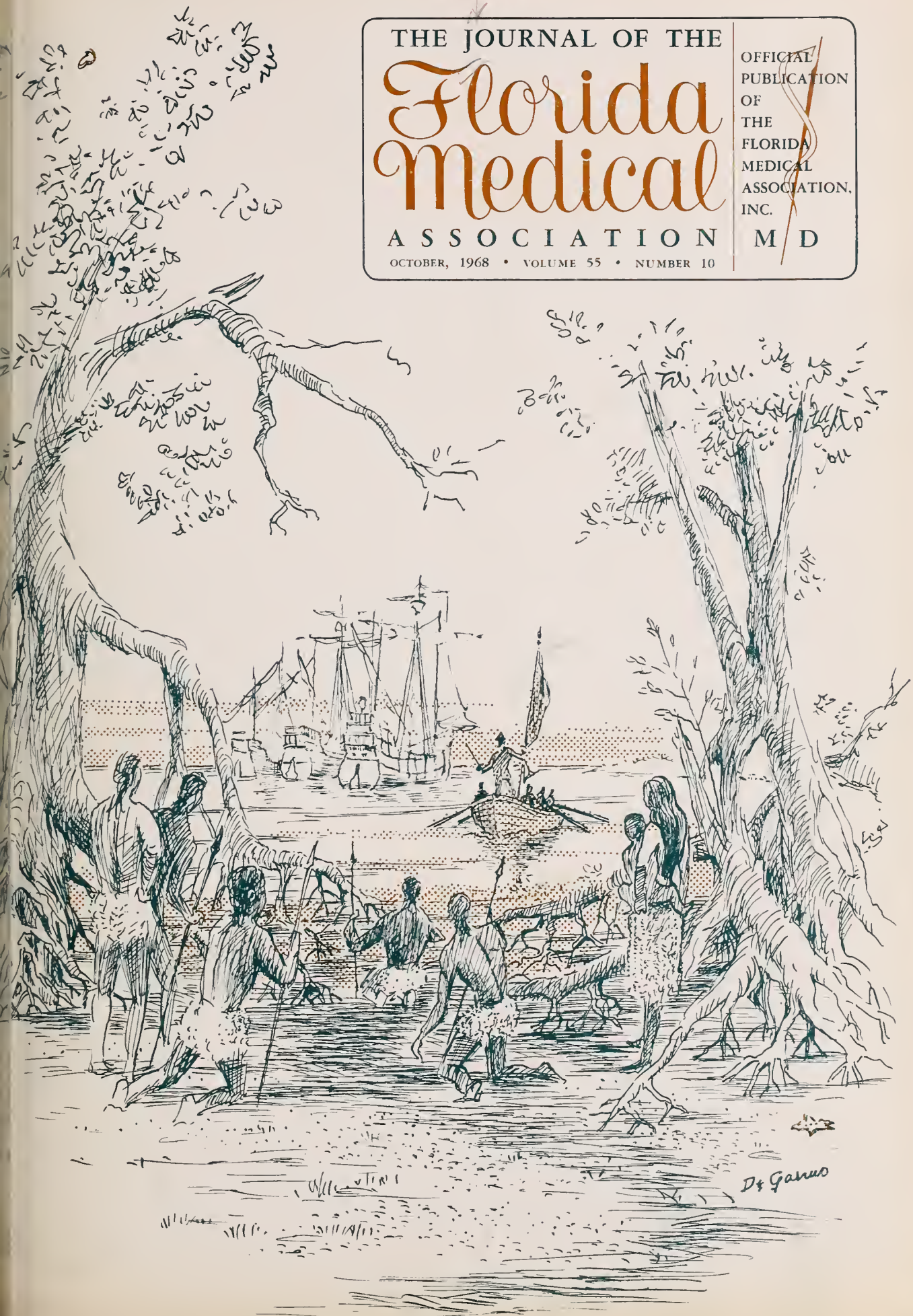
THE JOURNAL OF THE

Florida Medical ASSOCIATION

OCTOBER, 1968 • VOLUME 55 • NUMBER 10

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M/D



Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

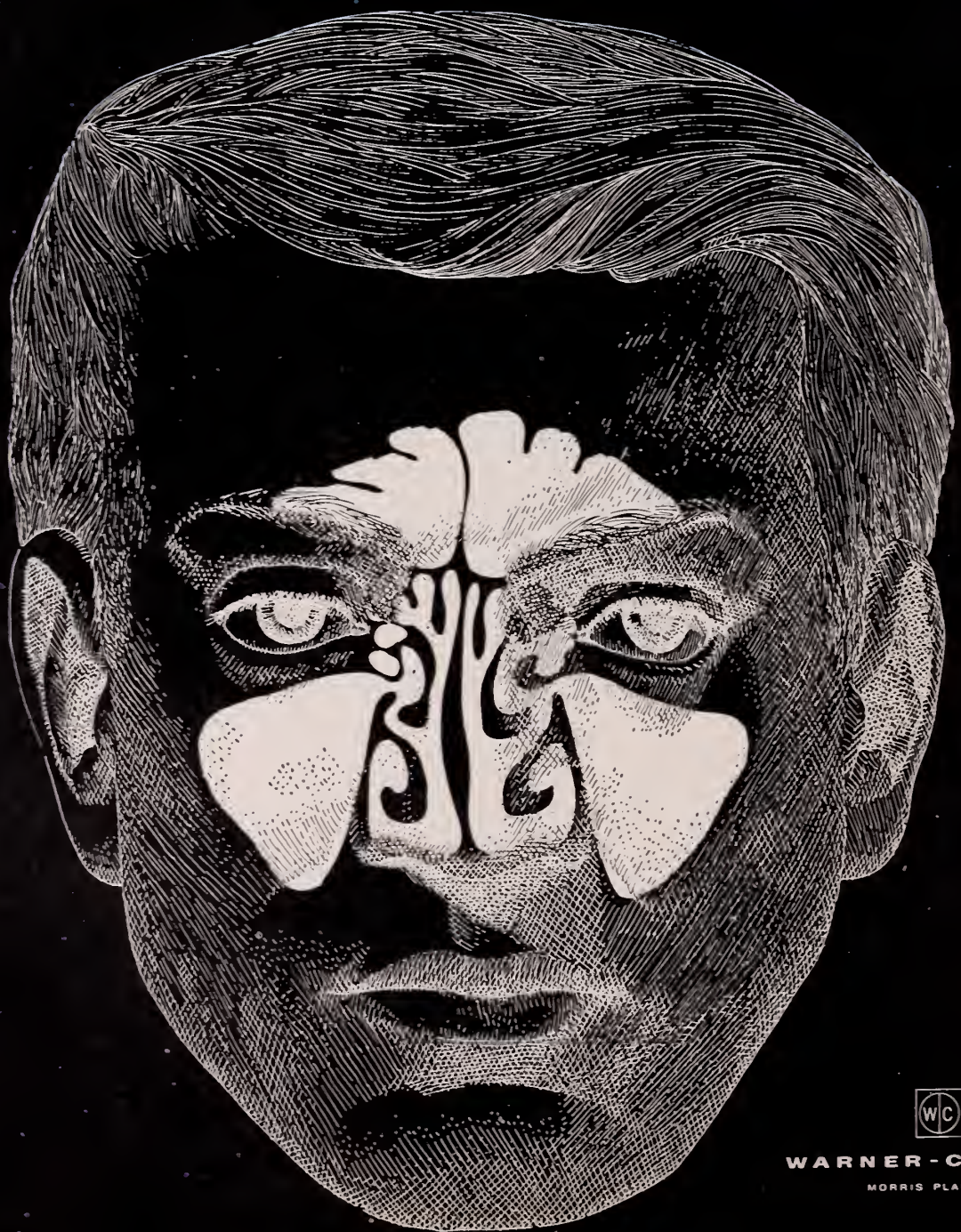
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WC

WARNER-CHILCOT

MORRIS PLAINS, N.J.

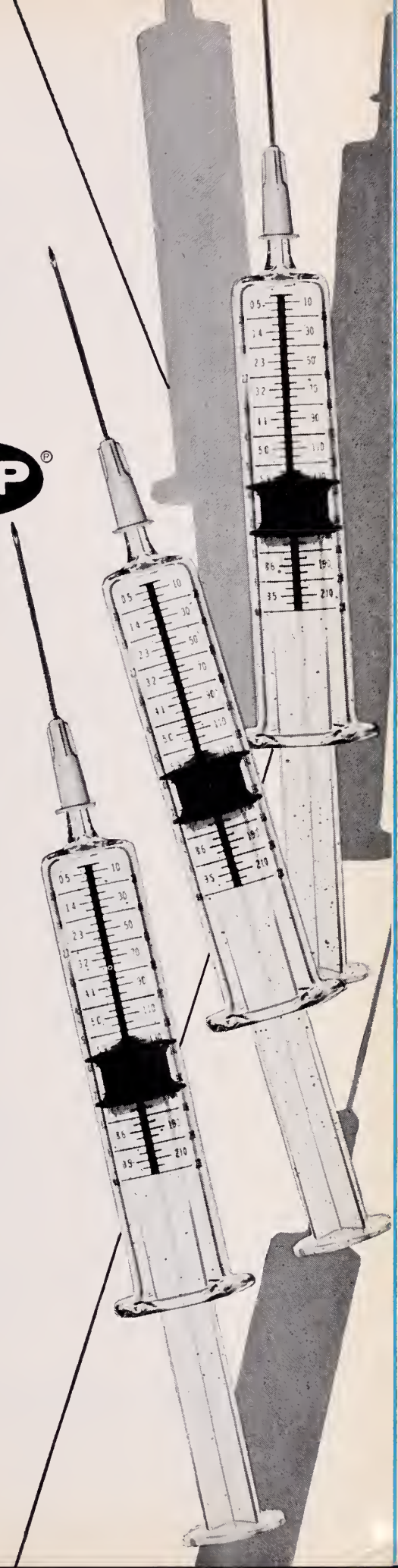
S-GP-86-2C

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN® IN A COMPLETE, STERILE, DISPOSABLE, & ECONOMICAL PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

H&D (BSP03)

BALTIMORE, MARYLAND 21201

THE JOURNAL OF THE
Florida Medical
ASSOCIATION
OCTOBER, 1968 • VOLUME 55 • NUMBER 10

scientific

Introduction 897
THAD MOSELEY, M.D.
Dyslexia and the Private Practitioner 898
CURTIS D. BENTON JR., M.D.
Dyslexia and the Research Ophthalmologist 903
MELVIN L. RUBIN, M.D.
Dyslexia and the Neuro-Ophthalmologist 906
J. LAWTON SMITH, M.D.
Eye Care and General Medicine 910
WILLIAM H. ANDERSON JR., M.D.
Ocular Problems of the Elderly 912
CECIL C. BEEHLER, M.D.
Diabetes: Diagnosis by Retinoscope 915
NATHAN S. RUBIN, M.D.
The Eye and Whiplash Injuries 917
WILLIAM J. GIBSON, M.D.
Recent Advances in Cataract Surgery 919
THOMAS S. EDWARDS, M.D.
Contact Lenses: Their Place in Medicine Today 923
FREDERICK E. HASTY, M.D.
Responsibility of the Pediatrician and the Family Physician for Prevention of Blindness in the Preschool Child 926
YOUNGER A. STATON, M.D.

features

The Admiral's Physicians 949
WILLIAM M. STRAIGHT, M.D.
Republican and Democratic National Conventions 963
WILLIAM B. WELCH, M.D.

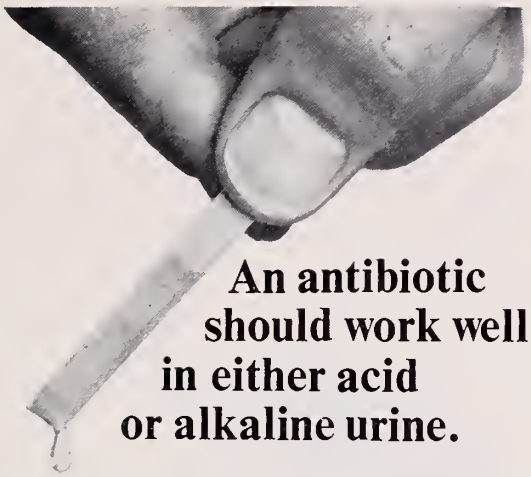
sections

Comment 937
Deaths 979
Editorial 931
Medicolegal 957
Organization 967
President's Page 885

information

Advertisers 983
Classified 980
Florida Medical Association Officers and Council Chairmen 982
Information for Authors 883
Meetings 973

Owned and published by the Florida Medical Association, Inc. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York



AMA

22ND CLINICAL CONVENTION

MIAMI BEACH

DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number, 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE
Florida Medical
ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

OSCAR W. FREEMAN, M.D.
Assistant Editor

RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

LOUISE RADER
Assistant Managing Editor



OCTOBER COVER

We are indebted to Kenneth DeGarmo, who did our cover this month. How did the Indians view the arrival of the first Europeans to the shores of the New World? This is his concept of the arrival of the first flag to fly over the Caribbean Islands and Florida, Oct. 12, 1492.



Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 486

You won't have to wait for these results to come back from the la
Because now you can do blood chemistry tests in your own office. Wit
Diagnostest* reagents and instruments. You get accurate, precise result
in minutes. And we teach your nurse or medical assistant to do the test.
The system can be used to measure hemoglobin, glucose, cholesterc
urea nitrogen, total bilirubin and uric acid. Write today for full details.

*Trademark of The Dow Chemical Compa

DOW



Florida Regional Medical Program

Our President, Dr. Jack Q. Cleveland, invited Dr. H. Phillip Hampton, state chairman for the Florida Regional Medical Program, to write the President's Page this month—Ed.

The Regional Medical Program has had a slow but steady start in Florida, primarily because of the organizational structure which has been formed to be representative of major medical and educational groups in the state.

Three areas of the state have been roughly delineated: the southern area about the University of Miami medical school, the west-central area about the developing University of South Florida medical school and the northern area about the University of Florida medical school. Each area now has an office and staff directed by part-time coordinators.

Beginning in October 1968, we are fortunate to have a well qualified full-time state director for the Florida Regional Medical Program, Dr. Granville Larimore, who has an outstanding record as a medical administrator and educator. Dr. Larimore plans to travel extensively about the state and will maintain his central office and staff in Tampa.

Task forces in heart disease, cancer, stroke, public education and medical education have been named and met for their first general conference September 7 and 8. Supplemental planning grant applications have been submitted by two of the areas and several operational grants were approved by the Florida Advisory Group meeting on August 23. A contract has been made with the foundation of the Florida Hospital Association to make a detailed study of hospital facilities, services and paramedical personnel.

The Florida Regional Medical Program is now well organized and directed and, with the cooperative participation of medical schools, hospitals and the practicing medical profession, it is capable of making real progress in improving medical communications, education and efficiency, all directed to the ultimate goal of achieving excellence in the delivery of medical care.

H. Phillip Hampton, M.D.
State Chairman
Florida Regional Medical Program
Tampa

Stamas builds the OPEN FISHERMAN THAT LADIES LOVE

the new Stamas V-24 Tarpon is the world's only open fisherman with an enclosed toilet compartment. It also is the fisherman that is the eminently enjoyable family-fun boat. With an 8 ft. beam, it can be trailered anywhere. The Stamas-designed vee hull gives you a remarkably *level* and incredibly dry ride—at any speed and in any water. The 19 ft. cockpit is self-bailing, spacious, completely uncluttered. The center steering station provides 360° flybridge visibility, standing or sitting. Standard equipment includes teak trim, rod rocks, rod holders, self-circulating live bait wells, 120 mile range. The extra strength and stamina of Stamas hand lay-up fiberglas construction are standard equipment too.

Write for name of nearest Stamas dealer and for new brochures on Stamas V-24 Tarpon, V-24 Clearwater, V-26 Americana and other models.

Stamas BOATS, INC.
Tarpon Springs, Florida 33589



ACHROMYCIN® WORKS HERE
TETRACYCLINE



Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon*) concurrently.

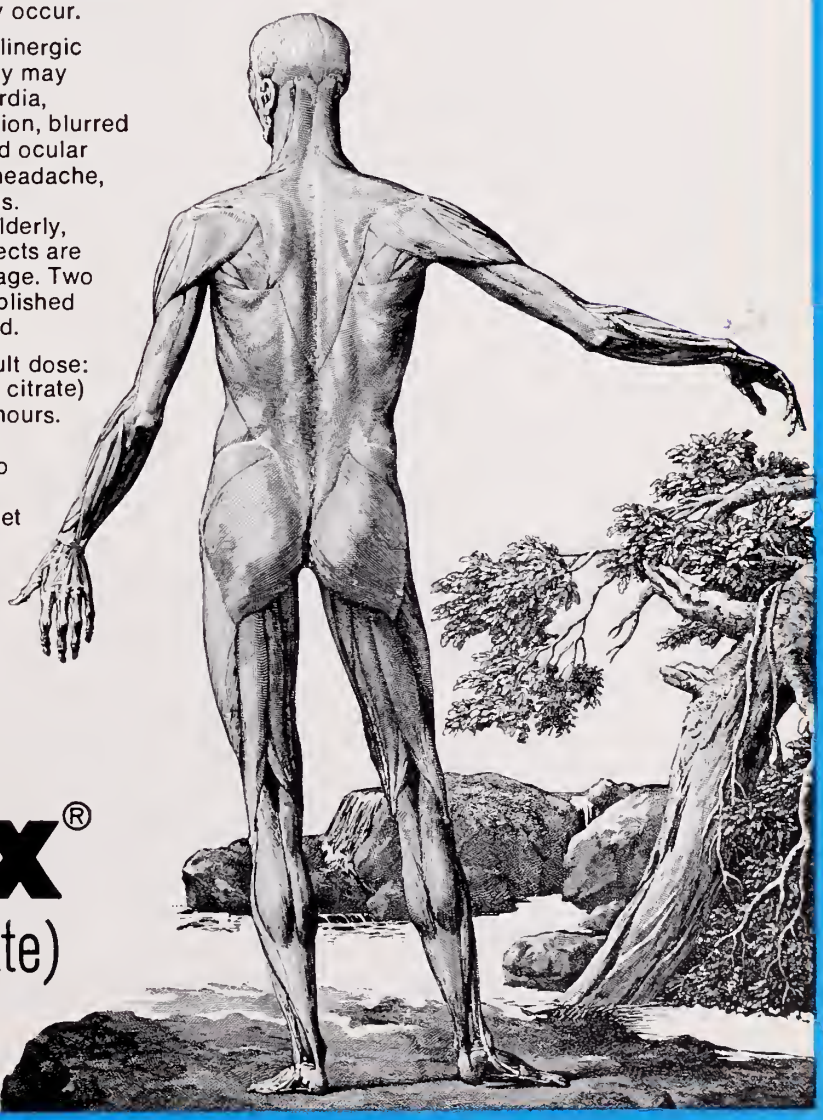
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

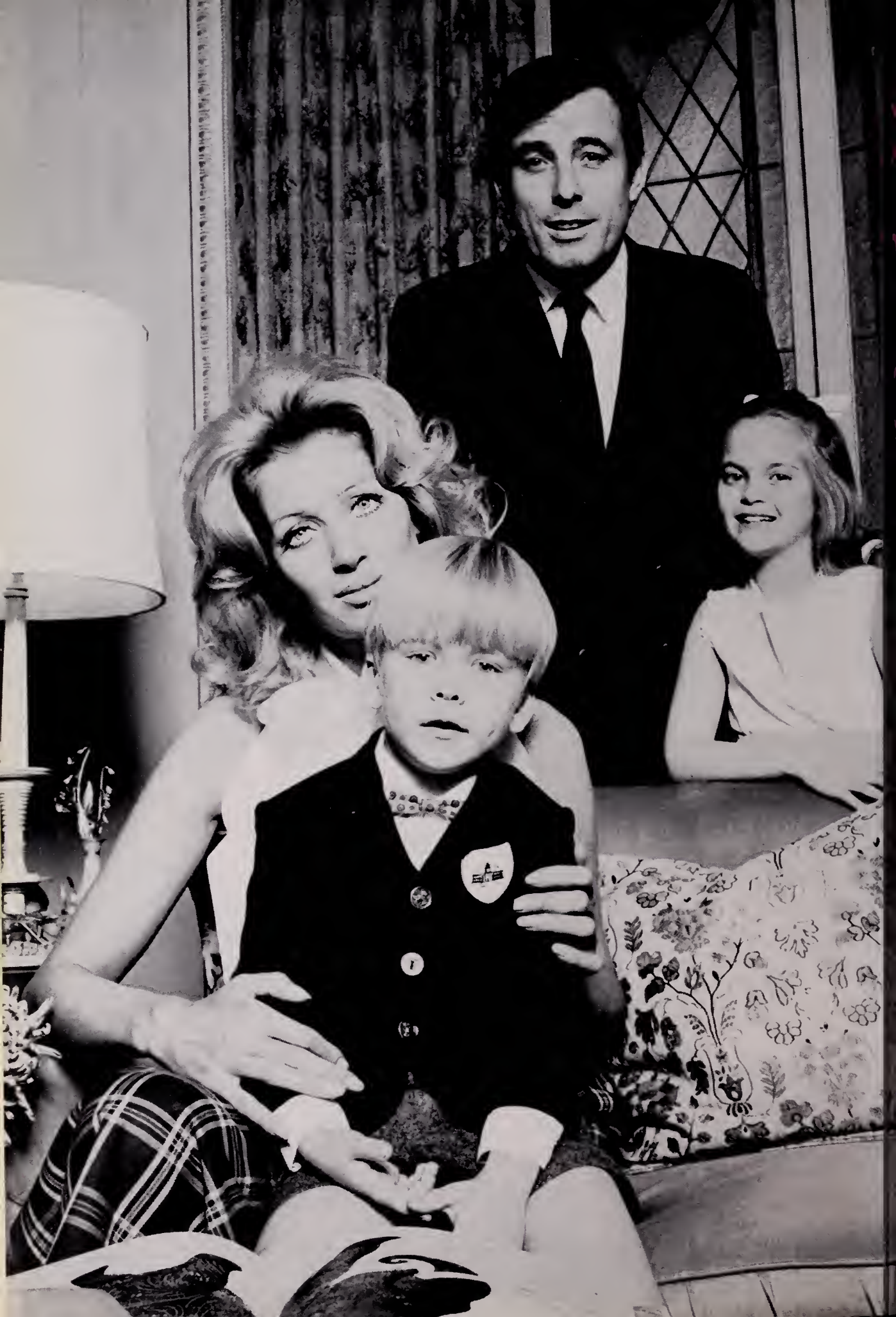
DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)



pinworms
n this
amily?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections in primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes group therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

...and if hygienic measures alone are not enough...?

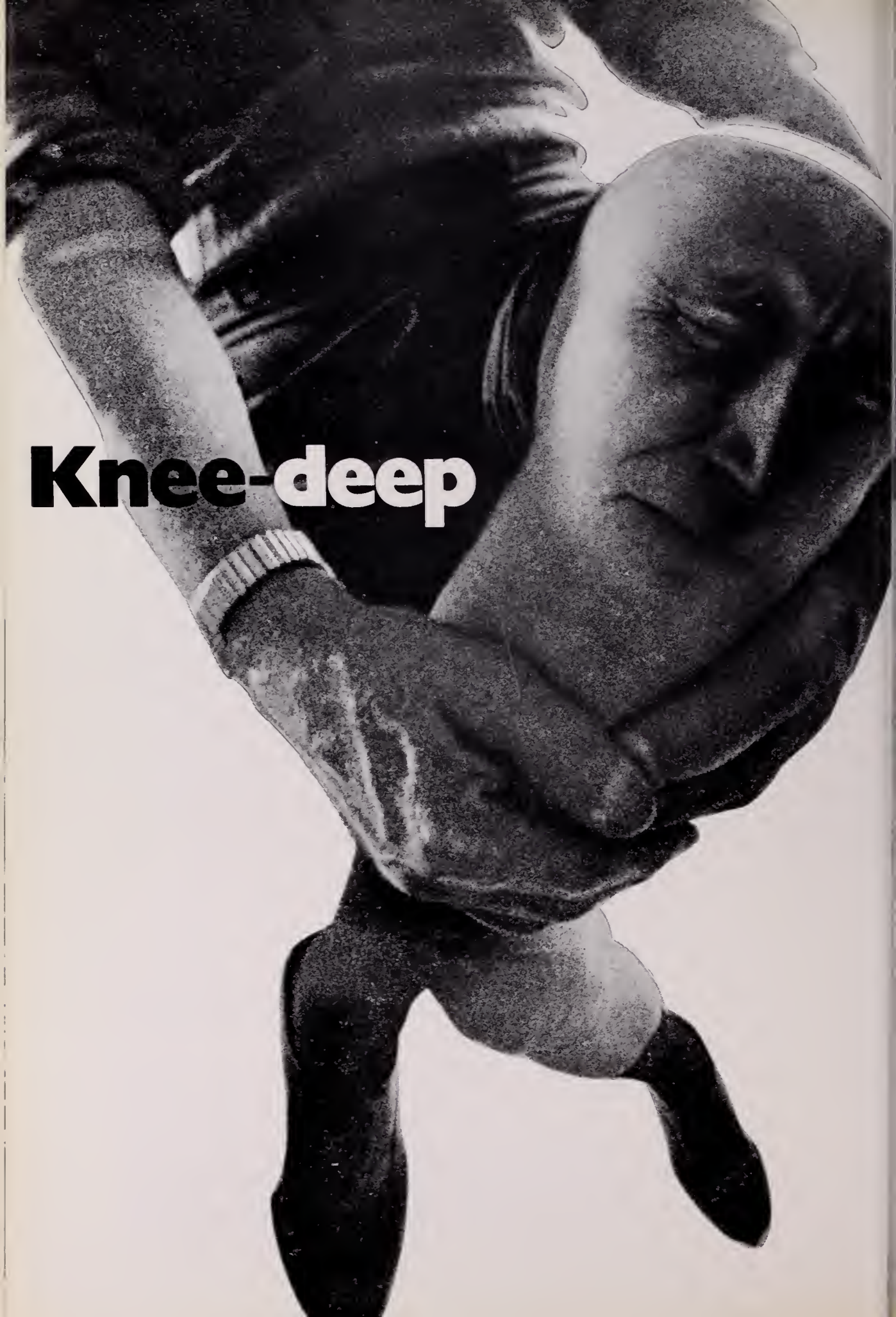
when examination reveals pinworm infection, estimated to occur in from ⅓ to more than ½ of all American children from every social level, an increasing number of physicians favor treatment with a single, economical dose of—

Povan®
(pyrvinium pamoate)

PARKE DAVIS & COMPANY DETROIT, MICHIGAN 48232

PARKE-DAVIS

33668


Knee-deep

n osteoarthritic pain

If aspirin doesn't help, move in
ı Tandearil.

The trial period is brief: 1 week.
one tablet q.i.d. at first. Tandearil
ally starts working within 3 to 4 days.
en response occurs, as little as 1 or
blets daily may hold back pain and
ness, and increase joint motion.

On the next page is a summary
dverse reactions, contraindications,
rning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

ıdearil, oxyphenbutazone:
r brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

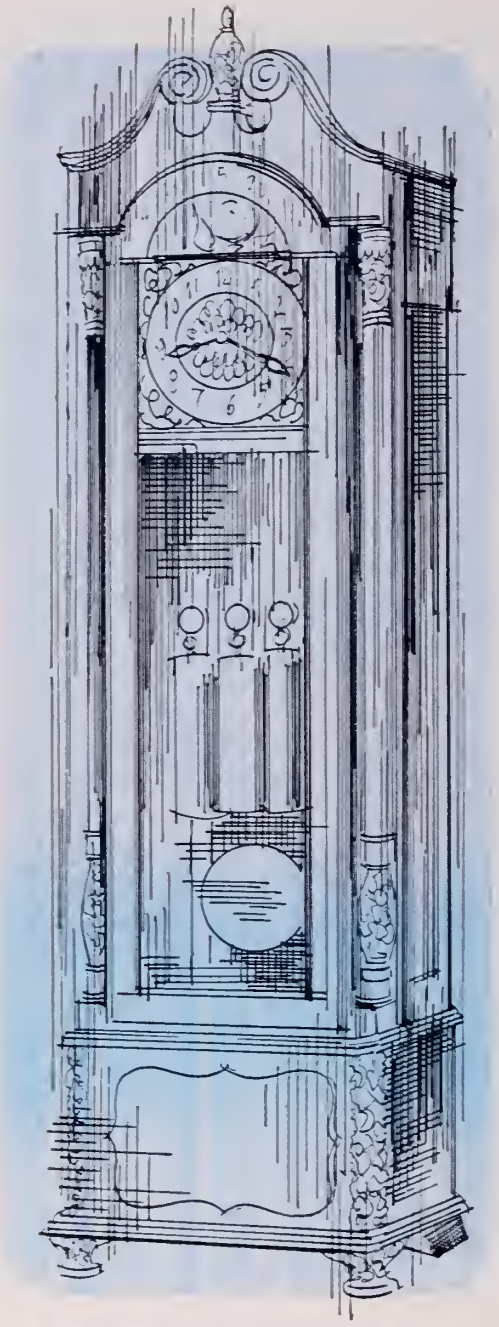
That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





IN UROLOGY, TOO,

YOU CAN'T TURN BACK THE CLOCK

Many urologic problems in older patients are as much the result of the aging process as the consequence of any specific disease process. The aging bladder may lose its resistance to infection. The prostate gland may not be sufficiently enlarged to require surgery, but can cause intermittent difficulties in micturition. Post-menopausal atrophy of the genital organs may also involve the lower part of the urinary tract.

URISED®

Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Even though they cannot be permanently cured, these patients demand and deserve relief. URISED is an agent which you can prescribe with confidence. It has a mild antibacterial action, a mild antispasmodic action and helps to soothe the irritated bladder and urethral mucosa. For over 50 years URISED has exhibited no toxic effects — even on prolonged use. And the presence of methylene blue in the urine is indicative that the medication has been taken by your patient.

INDICATIONS: URISED is safe... especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination.

Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: If pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day, followed by liberal fluid intake.

Acute cases: Initially two tablets every hour for three doses, followed by the recommended daily administration.

Children: One-half the adult dose.

(Stocked nationally through all service wholesale druggists)

CONAL
PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

• CYSTOSPAZ® • URISEDAMINE® • ŪTRASUL® Tablets and Suspension



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

It's almost as if you were there to give an injection of penicillin



dependable oral penicillin therapy V-Cillin K®, Pediatric

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, anu severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800197

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Florida Medical | scientific

Introduction

Toward Increased Understanding

Thad Moseley, M.D.

The trend toward specialization of medical practice has enabled the physician to better serve many patients, but with this concentration of interest frequently there is less interest in other areas of medicine. Consequently, some patient may be passed from physician to physician because of this inability to recognize a disease which belongs within another specialty field. The physician in general practice also finds himself in need of a ready reference concerning disease, as new diseases and new methods of treatment are described. To him, an authoritative, concise reference is most important, for he frequently is the first physician to see the bizarre diagnostic problem.

The Journal of the Florida Medical Association, with the cooperation of several state medical specialty group organizations, in past issues has brought to you as a continuing educational effort the opinions of knowledgeable physicians concerning facets of disease and treatment of specific disease. These symposia also have served to improve communication and understanding between the specialty group involved and the Florida Medical Association, for the two have worked together on a project of interest to all.

Under the direction of James W. Clower, M.D., immediate past president of the Florida Society of Ophthalmology, and the guest editorship of Curtis D. Benton Jr., M.D., this issue of the Journal is devoted to the discussion of newer developments in ophthalmology, ideas concerning utilization of some previously available treatments in ophthalmology and the relationship that exists between the eye and the other disease entities. I congratulate the guest editor and the contributing authors and recommend to each of you a careful reading of this symposium.

Dyslexia

Dyslexia and the Private Practitioner

Curtis D. Benton Jr., M.D.

No good definition of dyslexia presently exists, and this is one thing that needs to be done by national acceptance so that we will know what we are talking about when we mention dyslexia. For the purpose of this discussion, let us give a broad definition to the term and say that it means a selective retardation of reading skills, resulting in an observable gap between a child's progress in reading and his progress in other areas of learning. This implies a normal or even above normal IQ. The incidence of dyslexia is estimated by various authors at between 5% and 15% of the population. If we take 10% as an average figure, then in a place like Broward County, where I practice, a county with 90,000 school children, we could expect about 9,000 with this condition. With the present facilities for taking care of those so afflicted only a small number are getting any kind of attention.

I became interested in dyslexia in 1959 because of patients coming to my office with a history of some difficulty in reading, and wondering if perhaps it could be due to their eyes, this being the first thing that comes into the minds of teachers, parents and the public. So, limiting my practice more or less to pediatric work, I decided I would learn something about it and make some investigations.

In 1960, at the April meeting of the Florida Society of Ophthalmology and Otolaryngology, I presented a paper in which I described some of the findings we were making on children with dyslexia, based on a study of 100 children with this problem. There were 60 boys and 40 girls, but in reality it is much more common with boys than with girls. I reported at that time that about one half of them had some sort of behavior problem. There was more left-handedness and ambidexterity than in controls. By my criteria, I found more of these children to have a convergence insufficiency. I found more of them to have what we were calling crossed-dominance, and more of them had a rapid retinal rivalry when tested on appropriate targets on an amblyoscope. After making these observations independently, I discovered by searching the medical literature that an ophthalmologist and his wife in Philadelphia, Berner and Berner, in 1938 and again in 1953 had published papers in which they found a striking incidence of disorders of laterality in relation to handedness and what they called controlling eye. Also, I came across a publication by the controversial figure Carl Delacato written in 1959, in which he stated the majority of children with these reading disorders had some laterality problem, or, according to another of his concepts, the neurological organization was not properly developed in these children. Many of the things that these two authors had to say were similar to the results of our research, and therefore gave us a stimulus to proceed further.

In July 1965 another article from our office on the subject of dyslexia was published in the Journal of Pediatric Ophthalmology. At that time we were treating 250 children afflicted with dyslexia, and we again found that binocularity almost is a prerequisite for dyslexia. Dyslexia is very rare in monocular amblyopes, it is much more common in intermittent exotropia than it is in constant exotropia and when it is present in esotropia, it is almost exclusively present in small-angle, rapid alternators. Upon examination of patients before and after surgery for esotropia, an increasing incidence of dyslexia is found in those surgically corrected for esotropia after operation; hence our belief that binocularity almost is a prerequisite for having dyslexia. The incidence in

The three papers on dyslexia appearing herein under one heading are from a symposium presented at the December 1967 interim meeting of the Florida Society of Ophthalmology and are believed by Dr. Benton to represent the nucleus of the efforts of the Society. The authors wish to point out that the papers appear as transcribed from the verbal presentation and were not written specifically for publication.

this study, of boys versus girls, was three to one. We again found that these children had a significant amount of crossed-dominance, that is, a dominant hand on one side and the dominant eye on the other, or a mixed or incomplete dominance, whichever term you want to use. Together these amounted to about 60% of those with dyslexia. We found again an increase in the frequency or intensity of retinal rivalry, graded from 1+ to 4+. We found that 50% of these children had a very marked retinal rivalry and found convergence insufficiency in about 30%. In the normal population in that age group, convergence insufficiency is about 5%.

A more extensive report was made last year at the National Conference on Dyslexia in Philadelphia. At that time we reported our studies on 1,500 children with dyslexia and 300 controls. The controlling eye was on the same side as the dominant hand in 25% of those with dyslexia, on the opposite side in 42% and mixed (in which you could not determine) in 33%. In 300 normals, it was on the same side in 78%, on the opposite side in 8% and mixed in 14%.

Last year we tried to categorize those with dyslexia into four major groups. Since then we have changed our ideas slightly, but at that time we reported that there probably was one category of neurological (congenital, developmental or primary) dyslexia. This is an inherited neurological defect, and the diagnosis, as far as I am concerned, is arrived at in retrospect. Secondly, there is one category that we call the hyperactivity syndrome. Others have called it the organic neurological behavior syndrome. It consists of children who are extremely hyperactive, have a very short attention span, considerable difficulty in school, behavior problems and difficulty in learning. The third category, which we found to represent about 50% of all the children who have dyslexia when defined in its broad terms, involved those who had problems in binocularity and laterality. These we consider the eye cases. The fourth category included all other causes—auditory perception and difficulty, emotional problems, physical disabilities, home environment situations, lack of proper motivation, teaching methods and so forth. Those things previously listed as the major causes of dyslexia I personally believe are minor; oftentimes they are secondary and not the major causes.

In our studies, then, we began to place more reliance upon this controlling eye concept. We have found over the years that no reliance can be placed on sighting tests to determine dominance. Upon reading an article that states there is no relation between reading problems and dominance, determine, if you can, whether this decision was based on tests of sighting, like looking through a hole at a light on the wall, aiming a gun, winking one eye or similar methods. In our studies these methods have been found unreliable, and although we use such tests and record the results for purposes of study and statistics, we find that they do not provide a criterion for determining the dominant eye.

We also have found that our quantitation of retinal rivalry is not as significant as we originally believed, primarily because it is difficult to interpret and difficult for different observers to record the same results. For that reason, although we still test it and try to work it out, we believe that this is not a factor we can recommend as providing a reliable criterion. Nor have we worked out a simple way in which it can be tested—not all ophthalmologists have an orthoptic technician and a major amblyoscope with which to work.

In the large number of patients that we now have we find that convergence insufficiency is present in about 22% of those with dyslexia and in about 4% of those who are normal. We defined convergence insufficiency as the inability to maintain fixation on an approaching near object up to 5 cm. from the nose and to hold it for a count of five. It is interesting to speculate on what part it plays in dyslexia or what it signifies. To me, it means that there is some difficulty with binocular control when dealing with near objects and these children are making some attempt at suppression to overcome their difficulties. Therefore, in my opinion, the convergence insufficiency is a result of dyslexia. Incidentally, it does not affect the reading problem to correct this by the standard techniques. We do give exercises to correct the convergence insufficiency because it improves reading facility, but it does not cure dyslexia.

There are other characteristics that are found with considerable frequency within a large group of children with dyslexia, and I think nearly all observers who have studied the problem agree on these points:

1. A high family incidence of dyslexia exists. Dyslexia is found in the parents and in the siblings of these children with considerable frequency.

2. Among those with dyslexia, there also is a high incidence, higher than in the controls, of difficulty at birth, prolonged labor, anoxia, heavy medications or, in the early years of life, trauma, fevers and childhood infections.

3. Behavior problems are more common, affecting at least 50% of these children with dyslexia. The psychologists have made a great point of this in the past. In my opinion, the emotional problems are secondary to the dyslexia difficulty 99% of the time and involve rejection, the realization on the part of the child that he is not learning and failing to do the work that his peers are doing and other compensation reactions. Although these problems are present, psychological or psychiatric therapy intended to overcome them rarely will improve the reading difficulty, yet we must recognize these psychological difficulties are present.

4. A high incidence of hyperactivity is present.

5. All observers agree a high incidence of mixed laterality is present, although they do not always know what to say about it. There is poor identification of body parts. For instance, if you tell a child with dyslexia, "Show me your left hand," frequently the child cannot do it quickly and accurately.

6. A significant percentage of those with dyslexia have poor body muscle control.

7. A number of those with dyslexia have poor auditory memory. It is not uncommon if you ask of the mother if these children sing nursery rhymes or remember little poems as we did in childhood, that very frequently the reply will be, "No, they just never did this." Children with dyslexia cannot remember even one verse of a simple song and are very poor at following directions.

8. Many persons with dyslexia have a poor visual memory.

9. An increase of various neurological defects, such as EEG changes, are found in some persons with dyslexia. Speech problems are fairly common, and I am sure that there are many things we would be able to determine if we had better ways of testing; as it is, our present ways of testing neurological deficits are rather gross.

In presently categorizing patients with dyslexia, we are considering them from the point of view of the neurophysiological manifestation of what they show, in what area their difficulty seems primarily to lie, and, for our own purposes, we now are dividing them into three categories. One category we call visiomotor, which includes those patients having poor visual perception with a strong motor component; the second is visio-auditory, and it includes those with problems in auditory perception as well as the eye problems, and the third category we call visiooptic. The visiooptic category is related to the binocularity problems and other matters concerned with visual perception where the trouble seems to be confined to this area.

In working this out, for practical purposes, what do you do when a patient comes into your office with a history suggesting dyslexia? We find that it requires at least three visits before we can establish any kind of diagnosis. First, we do a routine full eye examination after taking a brief history to establish that, in fact, there is a problem. We do a refraction, the complete eye examination, but in addition we carefully watch for muscle balance, fusion and convergence. We also test stereopsis, although we have not as yet found that this really tells us anything. On the second visit, we have our nurse-technician obtain a longer history as to the nature, type and degree of the patient's reading problem. We inquire as to complications present at birth, problems of childhood, handedness of parents and siblings and family incidence of dyslexia. We then inquire about the neuromuscular development in the early years—age of talking and walking, whether there are any speech deviations, hyperactivity and/or other related matters. The nurse then tests for the controlling or dominant eye. We have had sighting tests performed, although this is just for our own purposes and statistics, and we do not believe the results thus obtained to be significant. In testing for the controlling eye, we originally used two charts put out by the Keystone Company. We now have put everything on one card. In each of the sets, one diamond, has a black dot in it; these dots become increasingly smaller. In one, under the A it has a black dot; under the other they are blank. And just the reverse under the B's. The theory behind this is that a child will, if he is seeing this binocularly, perform better when the dominant eye is seeing the black dots than he will if the dominant eye is seeing the blanks. If the dominant, or controlling, eye is seeing the blanks, this overpowers the other eye that is supposed to see the dots and will inhibit its ability to resolve these smaller and smaller dots. If you occlude the dominant eye that is see-

ing the blank spaces, the nondominant eye will continue to do better, read better and interpret more of the dots. If the eye occluded is the nondominant eye, there is no change in score.

We also perform a test based on a similar principle to determine a child's reading ability, monocularly and binocularly when presented with a similar situation. We are in the process of devising some new cards for this test because the ones now in existence were published 30 years ago; in addition, school books have changed and the children no longer recognize all the words. Speed and accuracy of each eye is tested separately followed by a test for binocularity; these results may confirm what we have previously found in the controlling eye test.

In administering the controlling eye test, we believe the child must have at least two acuity levels of difference for the results to be within the range of statistical significance. In recording the child's handedness, the main criterion used to determine the dominant hand is the hand with which a child writes, eats and throws, primarily the hand used for writing and eating. Additional and supporting information also is used—inquiring as to which hand is used to comb the hair, for example. We previously tested for footedness, but we have found these results unreliable.

We have found it necessary to perform additional tests in order to determine whether the problem lies in the motor, auditory or visual area. For this purpose we have five tests that we administer—not all five to every patient, but individually as indicated. One test is the Bender Visual Motor Gestalt; the second is the Marianne Frostig test of visual perception; the third is a test for pure tone audiometry, and the fourth is a test of auditory perception known as the Slingerland test of language disability. It is not advisable to do a test of auditory perception unless you have first obtained a pure tone audiogram to be sure no hearing defect exists. The fifth test used is the Purdue perceptual motor test, which determines identification of body parts, laterality and fine and gross muscle coordination.

The areas of difficulty shown by the previously mentioned tests are:

1. Results of the Purdue and Bender tests are usually abnormal in the motor group.

2. The audiogram and the Slingerland test refer to the auditory group.

3. The Frostig and again the Bender, which is a visual motor test, show up in the visual, or ocular group. For some children we have to do all of these tests to determine what the problem is; in others we may do two or three or four.

In the visiomotor group, hyperactivity is a prominent symptom. These children present with a history of crying a great deal as infants and do not sleep very well. When a child so afflicted is in your office to be examined, all of your equipment is in jeopardy; the child is in and out of the chair, pumping it up and down, testing everything, fingering everything you have in the refracting room; the mother expresses frustration, fatigue and defeat.

In the auditory group, speech problems sometimes are present. These children present with a history of weakness in phonics; they do not remember children's nursery rhymes, do not sing little children's songs and so forth.

In the visual group, the trouble is primarily with the visual memory; these children present with all the typical signs and symptoms of dyslexia—reversing of words, skipping of small short words in sentences, calling words wrong, difficulty with recognizing new words and poor comprehension of what they have read.

In any of these three groups, we may find any of the eye abnormalities such as convergence insufficiency, controlling eye on the opposite side of the dominant hand or, in a significant number, no establishment of real laterality. These children are in a state of flux.

Our treatment is directed first of all at establishing the proper laterality, and secondly toward counseling and recommending help in the areas where the other tests show weaknesses—trying to put them in the right type of remedial reading program, for example. Where an auditory difficulty exists, the child is taught through visual methods. Where there is a visual difficulty, auditory learning is stressed. These children are behind academically; they have to catch up. It is not uncommon to get a child who has been to remedial reading classes and been tutored for quite a long time without making any progress. Once the binocular problem is corrected, their progress is sometimes dramatic. If we can determine a definite handedness, we try to establish eye dominance on the side of the dominant hand. We do this in young children by constant occlusion of the eye that we wish to be nondominant, and in the older children by the use of atropine drops every school morning. We ask them to discontinue the drops one week out of each month

and definitely to discontinue them for a week or ten days before coming to the office for reevaluation. We find that it requires usually nine months of such treatment to establish proper laterality or reverse dominance; sometimes it takes a year or a year and a half. We then try to follow up the patient long enough to see that the correction remains without further treatment.

One other important aspect of treatment remains to be reported. For the children presenting with hyperactivity, originally we prescribed tranquilizers; such treatment produced the opposite effect from that desired. Now we find that the psychic energizers, particularly methylphenidate, given in doses of 10 or 20 mg. (depending on the child's size and age) before school each day, has a remarkable beneficial effect. In those that do not tolerate the methylphenidate, we use deanol, 100 mg. Some of them have been treated with dextroamphetamine sulfate, but our choices are methylphenidate and deanol. This treatment increases the ability to maintain concentration on a task and facilitates learning. The effect is so dramatic that, oftentimes, if the mother in a rush forgets to give the child a pill in the morning, the teacher will call home and ask what happened. In summary, we change the eye dominance if needed. If they have not established a hand dominance, we try to determine which side should be dominant and encourage such dominance. If they are mixed-handed, we try to establish dominance of one side and try to establish the dominant eye on that same side. We overcome any convergence insufficiency with routine measures. We give them drugs as needed. We try to guide them in the proper educational channels.

The results with 700 cases we have followed for as long as three years show that excellent improvements were obtained in 49%, moderate improvement in 39% and failure in 12%.

Such results are not meaningful unless you know what we consider excellent improvement or moderate improvement. At present, if the child is able to catch up to his class and begin to read for pleasure, we consider this excellent improvement. If the child is able to make some progress and is at least able to pass and keep up, this is moderate improvement. If the child just does not get any better, of course, we would consider this a failure.

We do recognize that a big factor in treatment is just calling attention to the problem, letting the parents understand that a definite problem exists which is not the fault of the child. The parents are critical of the child when he is not performing well; believing the child is at fault they exert more pressure, which is just the thing the child does not need. I do not know how you can divorce this psychological element from the other areas of treatment, unless control studies can be run, which Dr. Rubin will discuss in a separate paper. By calling attention to the problem we hopefully promote an element of understanding, help and cooperation between the parent and child, whereas before there existed conflict and anxiety. On the other hand, we have had enough patients who have shown remarkable changes so rapidly that we believe there is something definite here and that this deserves further study by ophthalmologists to determine, as best we can, exactly where the truth lies and what we can do to help.

Most of the literature will say that the treatment of dyslexia is an interdisciplinary approach, that it requires cooperation from the pediatrician, the neurologist, the educator and the psychologist as well as the ophthalmologist and, occasionally, the otologist. Still, somebody has to take enough initiative to guide the patient through this network of the team. I have become interested in such guidance and have been willing to do it myself, which means it was necessary for me to learn something about the other disciplines mentioned. I do not think dyslexia is something for all ophthalmologists to treat, because they all do not have the same type of interests. I do think, however, the ophthalmologist should know enough about dyslexia so he can at least guide his patients, not have them come into his office, receive a routine eye examination and hear him say, "There is nothing wrong with your eyes—you must go somewhere else," for then they just go from pillar to post and never get anywhere. Unless you have someone to whom you can refer the patient, someone whom you believe will carry through, then you have not done the child much of a service.

▶ Dr. Benton, 1800 East Las Olas Boulevard, Fort Lauderdale 33301.

Dyslexia and the Research Ophthalmologist

Melvin L. Rubin, M.D.

Let me step back for a moment and point out that the problem of dyslexia is currently boiling all over the country. It is receiving a lot of attention in both the lay and professional presses. Really satisfactory methods for both diagnosis and therapy have not been attained by any of the overlapping professions to which the public runs to for help. Presently there is a crescendo in the cry for diagnosis, guidance and therapy. Since the child reads with his eyes, parents understandably seek to correct any reading difficulty by turning to an ophthalmic practitioner who may be very uncomfortable with the problem.

So much controversial material regarding dyslexia is at hand and so many varied therapeutic approaches exist that one is at a loss to know exactly where to start in trying to evaluate anything in a scientific manner. For example, in evaluating any purported therapy, no one really knows the role of attention, the psychology of the child's interest, the effect of time alone on slow maturation (that is, the "late-blooming" type of child), the influence of normal growth and development or the true value of encouragement by the dedicated teacher and/or the parents. All these are factors which are almost impossible to exclude in any critique of remedial results.

There have been a few carefully delineated programs with a goal of improving the reading ability of children with demonstrable reading problems. Probably no method has received as much notoriety as that advocated by Doman and Delacato in their institute for the Achievement of Human Potential in Philadelphia. This group has devised a scheme for the management of children with brain damage of any sort, including that which may result in a reading problem. This group has received much publicity, some favorable and some not so favorable. Controversy continues to rage as to the validity of their claims. There is no doubt that they do tend to rationalize the resistance of others to accept their claims, or throw accusations at anyone critical of them. The cult has caught on, and now there are many branch institutes which are "franchised" in a number of areas around the United States.

Dr. Rubin is professor, Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

The major source of negative professional feeling toward the Doman-Delacato approach is the inappropriate publicity given to their claims of results. There are plenty of testimonials, but none are documented or supported in a really scientific manner; that is, no controls exist. It must be stated that Doman and Delacato are not the only group with an unusual or unconventional approach to the teaching of reading. In Time Magazine (Nov. 3, 1967) an article appeared which described the Chicago Reading Research Foundation; this group uses a shock-type technique to attempt to jar the children into attention and keep them from being distracted. The children are cajoled, tormented and actually screamed at by the teachers in an effort to control their attention and reading progress. Far from inflicting purely sadistic punishment, it is claimed that this group applied force and shouted commands to help children with normal intelligence who simply cannot learn to read adequately. Claims made are that so far the clinic has not failed to improve the reading ability of any child who sticks with the drills long enough. No one yet knows, however, whether the bullying technique which is used has harmful long range effects on the personality development of the child. In any case, the only reason I mention this at all is to point out yet another program with which you may be unfamiliar and which is advocated for helping children with dyslexia. Doman and Delacato do not have a monopoly on the bizarre, unconventional approach to the teaching of reading.

To return to the original subject, there is no question that the practical view presented by Dr. Benton in this journal is reasonable. His approach has many merits and actually has proven quite effective in his hands. There are certainly few people in the country who have treated as many children with this problem as has Dr. Benton, and fewer still can argue with his success. The fact that so many children have been improved by the technique points to the correctness of the empirical approach, that is, if it works, the onus is on us to prove it and show why it works.

Since becoming interested in the problem of dyslexia, we decided to try to evaluate the actual influence of the eyes in children with reading difficulties. We planned a study at the University of Florida Laboratory School in which we did complete eye examinations, including the labeling of a sighting eye, controlling eye (by Benton's cards), handedness and footedness in the same manner as described by Benton and Doman and Delacato. We measured the reading performance, correlating this with reading achievement and I.Q. All test results were determined independent of the others and different observers performed each of the tests in each category. For example, one technician would do all the reading tests and another would do all the sighting tests. All the children in the third, fourth and fifth grades, a total of 180 children, were evaluated in this manner and correlation of reading ability with laterality was attempted.

Other studies have shown, amazingly that, the most "obvious" factors, such as visual acuity and refractive error, did not seem related to the retardation of reading ability. Impaired visual skills, such as fusion, accommodation, and phoria can contribute to reading difficulty, but these factors do not seem to be primary. Other visual functions, however, such as form perception, psychomotor control and the ability to match visual and verbal configurations may be more closely associated with retarded reading or dyslexia.

What we found in our study of the Laboratory School children tended to confirm these findings. Our other results follow:

First, the reading skill was broken down into four categories. Thirty per cent of the children were excellent readers, 30% good, 20% fair and 20% of the children were poor readers. By poor, we meant they were at least 18 months behind the reading standard set up for each grade level. Understand this now! Twenty per cent of the children were markedly below grade level in reading ability. If this can be projected to all school children in the primary grades (and I do not see why it cannot), one-fifth are markedly below grade level in reading.

I would like to have you think for a moment about dominance. It is relatively easy to speak about a dominant or master hand or foot because we all know of the one-sidedness of dominance of the cerebral cortex. We also know, however, that each eye is *bilaterally* represented in the occipital cortex. How then can we think about eye dominance in the same way as we do of a hand or foot? That is a very good question which I cannot answer. We can only define, not explain.

With this in mind, all children in our study were labeled as to being homolateral, mixed dominant or cross dominant. Actually, there are many types of "dominance," many types of lateralizing phenomena, many different types of specific eye dominance; therefore, we are defining our terms as follows: a.) Homolateral Dominance-eye and hand dominant on same side; b.) Cross Dominance-eye dominant on one side, hand on other, and c.) Mixed Dominance-no definite preference.

To determine these dominances, we utilized the handedness and footedness preference tests, as previously detailed by Dr. Benton. For the eye preference test, we subdivided into two categories, "sighting" dominance and "controlling eye" dominance as described by Doman and Delacato. I would like to emphasize this distinction between sighting and controlling eye. The sighting eye is the eye chosen for monocular tasks, for looking through a keyhole, sighting through a tube, using a monocular telescope, sighting a rifle—this type of task. The subject has a choice of using either eye and usually prefers and choses to use one over the other. That eye is his sighting eye. The controlling eye, on the other hand, is that eye which tends to be used when both eyes are open and in use simultaneously for the same task, such as in reading. With the Benton "controlling eye card," you can determine which eye seems to have "more to say" to the cortex than the other. In other words, more attention is paid to the information which is gained from one eye than from the other; the second eye is open and being used, but the cortex is more or less ignoring the information contributed by it. Looking at it another way, one eye interferes with the vision of the other. The eye which does the interfering is the controlling eye.

At first thought you would think there would not be much difference between the eye which is labeled "sighting" and the one which is labeled "controlling," but in our series the correlation between the two is not very good. In other words, if the right eye is labeled the sighting eye, the chances are only slightly better than 60% that the right eye will also be the controlling eye—40 children out of 100 will have the left eye controlling with the right eye sighting. Therefore, in labeling a child as homolateral, mixed dominant

or crossed dominant, it is important to state which eye test is used to determine the conclusion.

Now, when you try to correlate the sighting eye with hand lateralization and reading ability, you will find there is no significant correlation. This finding seems to agree with all other studies which have been done that show no correlation between eyedness, handedness and reading ability. The Journal of the American Medical Association of Oct. 30, 1967 published two articles discussing the Doman-Delacato approach to retarded readers and the "patterning treatment" for brain-damaged children. Both are critical of this approach and both are excellent articles. But note this—the laterality determination (Robbins') was done by averaging a number of tests which determined handedness, a number of tests which determined footedness and a number of tests which determined eyedness. It is the latter with which we have quarrel. Four out of five of the eye tests were sighting tests (the fifth was the controlling eye test). In other words, if four out of the five point to one eye as the sighting eye, it is obvious that sighting would have much more weight in the determination of eyedness than it should. If, then, that eye is used to determine whether a child is homolateral, cross dominant or mixed dominant, then we would predict from our own findings that he would find no difference in reading ability and lateralization (Remember, we found no correlation between sighting eye lateralization and reading.) This is indeed what he found—no correlation. This finding no doubt will be played up by all skeptics. On the other hand, when we determined the correlation of reading ability with laterality using the controlling eye instead of the sighting eye, we found an apparent good correlation between homolaterality and reading ability. If a child was labeled homolateral by controlling eye, then he had an 80% chance of being a good or excellent reader. This is in contrast to about a 50% chance if he were labeled homolateral by the use of sighting eye.

Other correlation studies were carried out as described by Bettman in the December, 1967, Archives of Ophthalmology, that is, we determined how many of the children classified as "excellent" readers were homolateral, how many of them were crossed and how many of them were mixed dominant. Of interest are the percentages which are almost identical with Bettman's, only we consider them significant (our series was much larger):

	H	X	M		H	X	M
Excellent	53	16	32	E & G	43	17	40
Good	33	17	50				
Fair	19	23	58	F & P	23	20	57
Poor	25	17	58				

We found that the highest percentage of the excellent readers, about 53%, were homolateral and the highest percentage of the poor readers, about 60%, were mixed dominant (only 25% were homolateral). As the reading skill diminishes the percentage of homolaterality decreases while the percentage of mixed dominance increases. Cross dominance does not seem correlated, since about the same percentage of children were found at each reading level.

From this initial sample then, we conclude that if a child is homolateral he has an excellent chance of being a very good reader. Because of this, we hoped that increasing the child's chances for becoming homolateral might increase his reading ability. This hypothesis remains to be proven scientifically; it is doubted verbally by Bettman's study, but he did not undertake any trial of therapy. As we said initially, however, because the clinical trials of Benton seem to show some positive effect on reading skill, we decided to try to make children homolateral by patching (or pharmacologically patching) the eye we do not want to have the controlling eye status. This is part II of our scientific study and is presently being undertaken. The attempt will be to see if simply patching or using a drop of atropine in the eye we do not want to assume control will in any way influence reading skill. We periodically will monitor the child by concurrently testing for controlling eye and reading achievement. This study is being undertaken on a double blind basis: we are using a control placebo drop of 10% phenylephrine, which will dilate the pupil but will not cause any cycloplegia and therefore should have no effect on reading ability of that eye. The treatment drop is 1% atropine given one drop a day, in the morning, in an attempt to blur the accommodation of the eye. We have the children divided into dyslexic readers, generally slow-readers and normals. The dropper bottles are labeled A and B and we do not know which is which. We hope to have more information next year at this time as regards to this scientific study.

We are undertaking another pilot project, however. All dyslexic children selected for the study are referred to our central coordinating physician and pediatric neurologist, Dr. John

Ross. After full clinical and neurological examination, he schedules the patients for EEG's, tests by our psychologists for manual dexterity, symbol interpretation and so forth and then to a complete eye evaluation. The children so chosen are being treated only with atropine drops in the eye from which we want to remove control. We allow them free access to a black pirate patch if they desire. In a partially scientific manner, then, we are investigating other parameters which may be influenced by treatment. We say partially scientific, since we have no controls in this small pilot group of children. As an aside, it is really amazing how many patients present with reading problems when you announce you are studying dyslexia in children.

So far—it has now been almost nine months since we started—these children (of our own medical faculty and outside referrals) do very well, some amazingly so. You must realize that these children are not "underprivileged." In the past they have had the benefit of many tutors in reading and very interested, enlightened parents, and still the children had not progressed in reading skills as they should have. After starting the atropine drops and without changing anything else in their daily routines, I was quite pleased to find a remarkable change in some—and some improvement for the majority. Before you accuse me of presenting testimonials, as I have so harshly accused others, I would like to stress that it was specifically because they were doing well that we decided to undertake the study with the Laboratory School children.

What does all this mean regarding the Doman-Delacato conclusions? This I cannot tell you. We do not do any of the patterning, creeping or crawling which is described by their group and yet we do seem to get some results. Perhaps we are fooling ourselves. The controlling eye may have something to do with it (we think it does) but on the other hand, it may turn out that it has absolutely nothing to do with it; perhaps we are influencing some other parameter about which we know nothing at this point. What we must stress is that even if the atropine "patch" seems to improve reading, this does not infer anything at all about the connection with lateralization of eye and hand. In any case, the findings should prove to be very interesting, whether the treatment proves to help reading or not.

I hope the water is not too muddy now, and you will at least be up to date on current activities in the very important economic and academic problem of reading difficulty.

▶ Dr. Rubin, University of Florida College of Medicine, Gainesville 32601.

Dyslexia and the Neuro-Ophthalmologist

J. Lawton Smith, M.D.

Dyslexia is an organic disease until proven otherwise. In my experience, dyslexia is an organic disease well over 90% of the time. It is not related to a poor home environment. It is not related to the fact that life is hard. It is related to the fact that you have a disease process involving the posterior midcerebrum of the dominant hemisphere well over 90% of the time. I want to give you four things to look for in your office on examining a child who is said to have a reading problem. Four types of pearls: four gems under each.

A child comes in and the mother says, "This child cannot read well, has a dyslexia problem." The first thing you do is a complete, good eye examination: externals, refractions, pupils, muscle balance, funduscopics, and, if the child is old enough for it to be done, visual fields. Most of them are not old enough to do good fields, as a rule. All right, we start with an eye examination. The four things at this point that I think will pay off: four facets of history, four facets of general inspection, four additional eye examinations and four types of tests.

Dr. Smith is associate professor of ophthalmology and assistant professor of neurology, University of Miami School of Medicine, Miami.

History

1. You have to take a better history in these patients than you do in other children. This means a family history and an obstetric history. What do you want to know? First, is the date of birth and the birth weight. There is a very high incidence of prematurity in these chil-

dren. Also, there are some that have excessive birth weights, when the mothers have diabetes, for instance. If the child weighed nine pounds or over, you should get a good postpartum sketch of the mother. If the child was definitely premature, you have to ask some other questions. Did the mother have something like rubella or viral infection during the pregnancy? Has she had 17 spontaneous abortions before this child came along? A good family and obstetric history—it violates the rule of ophthalmology, but you have to take it.

2. What are the developmental landmarks? You should know them. When could he sit, stand, talk, when was he toilet trained?

3. Has he had seizures? I had a patient in the office last week who went to an "Institute" and has been given reading tests and training since 18 months of age. They flash a bright light in the child's eyes ten times in a row three times a day to exercise the pupils. The child is having seizures every 40 seconds and is inadequately controlled in the medical management of the seizures. You do not have to be any atom-smasher to know that you better quit exercising the pupils and institute more antiepileptic medication if you want to properly treat that patient.

4. Finally, you should ask about handedness. I want to know whether the patient is perfectly right handed or left handed. If a child with a reading problem is left handed or ambidextrous, this is strong evidence, I think, that he has shifted to the right side or is trying to shift to the right side. It is not that he is left handed on purpose—maybe, but that is a tip to you that he is trying to shift. Find that out.

General Examination

In conducting a general examination, what do you do? You do not have to do anything outside of ophthalmologic criteria. We examine everything carefully outside the clothes. We do not believe in patients removing any clothes for the examination. I am an ophthalmologist.

1. Observe the child with regard to his general appearance, particularly the smile. By inducing a smile you may discover subtle central facial pareses that may not be apparent upon ordinary inspection. You say, "What would you do if a bear came down the chimney?", or, "What would you do if we gave you two funny books?", and a big smile pops out; it is then you see that relative weakness on one side—a very good neurologic sign to look for.

2. Compare the thumb nails; this is a big gem. There are only two things you have to know about pediatric neurology, one is to compare the thumb nail size and the other is to spin the baby. Put one thumb nail alongside the other and look at them carefully. You will see a smaller thumbnail on the side of a juvenile hemiparesis. It is a very subtle sign.

3. Pick up the child and spin it. This is pediatric ophthalmology and not applicable to the older child. Upon picking up a child to spin it in your arms, first be careful not to drop it; many of these infants have little strength in their shoulder girdles. Spin the child to the right and to the left. By spinning, you are testing cold-caloric attributes, semicircular response and optokinetics at the same time. Observe for good nystagmus when spinning the child both to the right and to the left.

4. Measure the head circumference. This is not necessarily applicable in the bigger children, those 10 to 13 years of age, but is important in the smaller or borderline children. Rather than ask to measure the size of the child's head, we have found it better to say, "I want to see what size hat you wear." It is very important to rate whether the head is on the small percentile side; if so, a subclinical microcephaly may exist. Note then: all you need do is compare the thumbs, observe the smile and measure the head circumference—nothing outside of ophthalmological procedure and no removal of clothing is necessary.

Eye Examination

1. Check the optokinetic nystagmus. I think if I had to emphasize one thing, this is the most important test in a child with dyslexia. This is a very important spinning test. You do not have to have a drum; in fact, it is better not to have a drum. The wife of my house officer made a tape for the test. Pick out any bright colored pattern. It does not make any difference what it is—any series of targets. Obtain the optokinetic responses of the child before taking the history. This is important. The only thing on which the child must cooperate is optokinetic responses. After taking a long history, an infant may be crying and disgusted; an older child may have given up. Walk up to the bed, do not say a thing, and start moving the tape. Do not say a word to the child, just have him watch the pictures. Judge the amplitude of nystagmus. You will never receive better vertical nystagmus than

is produced by this testing method. Expensive equipment is not necessary—a nice, pretty colored handkerchief will do. Grade the responses from 1+ to 4+, recording R (right), L (left), U (up) and D (down). Do not worry about the rapid phase, or what hemisphere—you will get confused unless you are familiar with this—just write down the response. When you take targets to his right, is there a 4+, good crisp nystagmus; to the left, is it 3+, or a little less? You will need to repeat the test several times. Several types of tapes also are needed. A child will get bored with a tape after one or two shots. Grade up and down. We will come back to interpreting this, but significant horizontal asymmetries in the optokinetic responses are warning you of a parietal lobe lesion in that child until proven otherwise.

2. Play the "E" game up through age 10 or 12. I saw a patient recently who had been seen by a prominent ophthalmologist who had seen the child at age eight and had had her come back to his office five times in six weeks trying to teach the child the "E" game to get the vision. The child could not learn the "E" game. At the end of five visits the doctor said, "I give up; I cannot get the E game." The child came here and we said, "Well, let's see how she does today." She said, "E, D, C, B, L," and so forth. Now that tells you something. She knocked off 20/15 on letters and numbers just like that, but she couldn't play the "E" game. In a child five years of age or over who cannot play the "E" game, there are only three explanations: one, the child has poor vision; two, the child is mentally retarded, or three, a parietal lobe lesion exists. Parietal lobe lesions are rare. In this particular case, the doctor had tried for five visits to teach the 8-year-old child the "E" game. We immediately suspected a syndrome in the nondominant parietal lobe. What are the symptoms of nondominant parietal syndrome? One is the inability to play the "E" game because the child has spatial disorientation. The child has right-left confusion. The child cannot get the concept that the hand does not go the way they want it to point. The "E" game is an important test in these children to discover right-left confusion and spatial disorientation. Another thing a child with dyslexia may have is dressing apraxias. One physician of our team was smart enough to ask, "Does she have any trouble with dressing?" The mother answered, "You know, it's funny you asked me that, because every time she tries to put on her pajama bottoms, she puts them on for the tops."

3. Check for spasticity of conjugate gaze. This is a nice screening test. To check for spasticity of conjugate gaze, it is very important to stand directly in front of the patient. Have him look straight at you. "Now look at me." "Close your eyes." "Open." "Now close again." Here is a very important point. Do not test both eyes at one time. You say "close," and you hold both eyes, and there immediately is a battle. The child will, however, let you close one eye at a time. Stand and carefully watch his right eye. You know that normally when you close your eyes they go straight up or up and out, they do not go down. In checking for spasticity of conjugate gaze, look for the eyes to consistently turn to one side. Notice half normal responses. Check both eyes. If the right eye went up and out, did the left eye go up and in? Check repeatedly; check four, five or six times, because often the eyes may be converging or performing in other irrational ways or you may be standing off to one side. But if a person, upon closing the eyes, consistently looks to one side, he is looking *toward* a hemiparesis or a hemianopia or *away from* a cerebral lesion. This is a quick screening test for lateralized hemispheral lesion.

4. Take an external photograph. I use this more and more and more. It is not primarily related to the dyslexic and is of great value when dealing with smaller children in which you suspect any pediatric or developmental anomalies. A child will let you do a lot as long as there is no anatomic connection. You can go up to a baby and do any number of things until the slightest physical contact is made. You cannot touch, but you can pull things, wiggle keys, shine lights and so forth. Approach the child with a Jenkel-Davidson clinical camera with a box on it. Get the camera as close to the child as possible without making physical contact. Project the picture. You can see a little asymmetry of the face that you missed initially; you can see an anisocoria you missed; you can see a little variation in lid aperture. Why? The picture holds still. Take a picture of those children—such a picture is worth its weight in plutonium in pediatric neurology.

Four Tests

Earlier I mentioned that there are four types of tests I think will pay. They are: one, EEG; two, skull films; three, physical examination—the only thing worse than no physical examination is

a poor physical examination; fourth and finally, I think it is sensible to get an FTAABS test (for syphilis) on the mother. Children do not like you sticking them, and, as many children have seronegative syphilis in the first place, I draw an FTAABS test on the mother.

If you want to go all the way, do a complete eye examination, take a family history and obstetric history and obtain the landmarks of neuromuscular development. Has the child had seizures or febrile convulsions? We were all taught in medical school that if a child has a temperature of 105° and has a fit, such behavior is not abnormal. Emphasis is changing, however; the child now has some type of low quality protoplasm and has a lower seizure potential than other children. Ascertain when the child had measles, when he had chickenpox, when he had an abnormally high temperature, when he had tonsillitis, has he had fits? Ascertain handedness. Observe the child for facial asymmetries, for gait, for a short attention span, for Café-au-lait spots, for cranial stenoses. These are symptoms that are obviously seen. Look for the subtle central paresis on the smile. Compare the thumb size as a quick screening test for juvenile hemiparesis and measure the head circumference. Test the optokinetic responses, administer the "E" game through age 12. You are not testing just for vision, you are testing to see whether the child has a parietal lobe lesion. Flip the lids when they try to close, look quickly for spasticity of conjugate gaze, take a picture if you have a clinical camera. If the patient can afford it, have performed some of the extra tests such as skull films and an FTAABS test on the mother. Upon return of the test results, it is not uncommon to find an abnormal pupil reflex, abnormal horizontal optokinetic responses or subtle central facial paresis. I think the treatment for dyslexia that is going to help cure is the treatment of the disease that is initially present. If the child has an obvious strabismus, a high degree of convergence insufficiency or exotropia, I would treat that and operate on him. I think that you should reduce any impediment the patient has. If the patient has epilepsy, he should be treated with anticonvulsants. If he has subclinical hydrocephalus or borderline hydrocephalus, he should be operated upon. If he has congenital syphilis, or toxoplasmosis, he needs to be treated. If he has craniostenosis or a subdural hematoma, he needs surgical relief. The minor dyslexics have a little patch of microgyra, porencephaly, some developmental malformation, and we are salvaging these during pregnancy with antibiotics, gamma globulins, better pediatric management and oxygen. When the dyslexic presents at age six or seven, he has a developmental malformation in the cortex; that is the crux of the matter.

Finally, how are you going to check the vision? I never will forget one patient. It is the hardest thing in the world to check the vision of an aphasic person. An elderly man came in and I said, "Well, I'll check his vision." I flipped up the 20/400 E and he had no more idea of what it was than flying to the moon. I opened up all the others; he could not tell me any of them. His son said, "Why don't you see if he can write it?" I gave him a pencil. He wrote it. He could write them all. Remember, if the patient cannot get the letters, go to numbers; a number of dyslexics can give you numbers but cannot get letters. If they cannot get letters, go to pictures. If they cannot get pictures, go to the "E" game. I prefer to use the isolated E card as it has a little more side phenomenon when you are working it yourself.

The last thing to try is to have the patient count fingers. I have seen a patient who could not even play the "E" game. You show a child three fingers and say, "Do this," and she sticks out her tongue. You say, "Do this and I'll give you a funny book." She holds up three fingers. Go down the hall sixty feet and she will do exactly the same thing. You can do the fields the same way; go up to her and say, "Do this." She copies you exactly.

Utilization of the four previously outlined areas will lead to the discovery of much neurologic disease in dyslexic patients.

▶ Dr. Smith, 9820 S.W. 62nd Court, Miami 33156.

Eye Care and General Medicine

William H. Anderson Jr., M.D.

The demand for eye care, like the demand for general medical care, is increasing faster than the supply. How to furnish the best medical care to the most people in all fields is challenging modern medicine. The only answer is to produce more doctors or use auxiliary and paramedical personnel to free the doctors to do what only they can do because of their training. In doing this, however, we must not lower the quality of medical training, nor allow paramedical personnel to usurp any of the functions delegated to them. This is a general medical problem, but all doctors can learn much from the problems that have been created in the eye care field. Let us analyze the problems.

As it has been and still is physically impossible for ophthalmologists to perform or supervise all the refractions required, optometrists through the years have performed this service for approximately one half the persons receiving spectacles. Most of these persons have normal eyes other than for a refractive error. In doing this, however, it was obvious that the optometrist should be capable of suspecting when an eye is abnormal and then to refer the patient to an ophthalmologist for diagnosis. Optometry recognized this as a weakness, and placed in their training curriculum such subjects as anatomy, pathology, physiology and so forth. The American Medical Association in 1950 declared it ethical for physicians to teach in optometry schools in an effort to help the optometrist recognize disease, and by so doing broke a 20-year precedent. During the next five years, it became obvious that optometry was using the association with physicians more for propaganda than for learning and it also became obvious that a person with no medical background could not be taught to diagnose disease. Consequently, in 1955 the AMA rescinded the 1950 action.

Legislation

Every year optometry has promoted legislation in various states to limit the rights of others, including ophthalmologists, and to increase their own. In Florida, the laws and opinions regarding optometry are not consistent. Optometry's charter, in brief, states that they can diagnose the eye in any way to determine the refractive status or anatomic anomoly, and prescribe lenses or any other means or methods for the correction, remedy or relief of any insufficiencies or abnormalities of the eyes.

Workmen's compensation laws and welfare laws more or less state that optometry shall be on a par with ophthalmology, yet optometrists, in opinions by the attorney general, have been declared as not legally able to diagnose disease or use drugs or to be a member of the healing arts. Neither are optometrists required to take the basic science examination, which would presume they are not to be held by law to be proficient in anatomy, physiology, chemistry, pathology or bacteriology.

Apparently, there may be only one solution—that of compromise. Even the AMA Judicial Council is relenting. Obviously, the lesson for medicine to learn is to try not to get into such a situation, paramedically speaking. After one gets in, however, what can be done? First, what can medicine in general do? Ophthalmology desperately needs help and understanding from the rest of the medical profession.

Fitting glasses, per se, is not a difficult art to learn but requires a large measure of honesty and understanding. Conversely, to recognize an abnormal eye requires considerably more astute observation and basic training. To make the diagnosis and then treat the abnormal eye requires the background of a physician. This same physician, an ophthalmologist, must be able to refract in order to determine the potential visual acuity in any eye in order to decide the best therapy, whether it be medical treatment, surgery or just glasses. He may use other personnel trained to do refractions, visual fields, tonometry, tonography and fitting of contact lenses and glasses, but he must be held responsible for analyzing the

Dr. Anderson is clinical associate, Department of Ophthalmology, University of Florida College of Medicine, Gainesville. He also is chairman, Committee on Vision, Florida Medical Association (1968-69).

findings, making the diagnosis, treating the patient and, above all, to certify that all work done by technicians under his supervision is accurate and that the patient gets the best possible eye care. On the other hand, optometry has repeatedly tried to obtain legislation making the services of these technicians a part of the practice of optometry and therefore illegal for the ophthalmologist to utilize.

Referrals

What about referrals? For a physician to accept a referral from an optometrist to determine the cause of some bodily symptom, such as headache, is just as ethical as acceptance of a referral from a druggist or anyone else. If the referral is made for the purpose of determining the cause of some eye problem or symptom, however, then the patient immediately should be referred to an ophthalmologist and should be told of the differences between optometry and ophthalmology. For a physician to refer a patient to an optometrist purely for glasses would be perfectly ethical, but the limited purpose of the referral should be made clear to the patient. On the other hand, if a GP, for instance, wishes his patient to have a consultation with an eye doctor for medical reasons, even if only to rule out disease, it would be highly unethical to even agree to allow the patient to consult an optometrist, much less actually refer him to one. The mere fact that a family has always used a certain optometrist for their glasses should not coerce you to condone his use as a medical consultant. If your patient had a back complaint for which you wished medical consultation, would you refer him to a physiotherapist or a chiropractor? Whenever a physician refers a patient to or condones the use of paramedical persons for medical consultations he tends to elevate their status in the mind of the patient and lends confusion to a poorly understood situation; neither situation is in the public interest.

What can ophthalmologists do? First of all we need to reach agreement among ourselves, then perhaps some mutual agreement may be worked out for coexistence with the optometrists. One area for this would be to agree to optometry taking intraocular tensions with topical anesthesia as a screening procedure—the same thing done by glaucoma screening projects. What better screening project could one have than for every presbyope who gets glasses to have his tension taken by an acceptable method and for this to occur each time he needs a change of glasses? For this privilege, optometry should agree not to treat or imply that they can diagnose or treat any disease, and this should include crossed eyes and amblyopia in the young. On the other hand, if an optometrist refers a cross-eyed child to an ophthalmologist and his need for glasses is established, the physician then should refer the patient back to the optometrist for those glasses. Similarily, if an optometrist refers a cataract patient to an ophthalmologist, the ophthalmologist in turn should refer the patient back to the optometrist for fitting the prescription for glasses. In both these instances the optometrist would be acting only as an optician, which he is both legally and practically trained to do.

Certainly, and most important, if the optometrist fails to recognize an obviously abnormal eye that should be treated, or if he treats such a condition in any way to the detriment of the patient even by numerous changes in glasses, he should be legally liable. Any agreements between medicine and optometry should be on a legal basis and so formalized.

Summary

A paramedical service, if not retained under the supervision of medicine, can and will become independent and even challenge the right of medicine to be the supervisor. Fields of medicine other than ophthalmology need not only to appraise their own paramedical counterparts, but to do what they can to prevent the efforts of optometry to legally or socially equalize themselves with ophthalmology, for this would be a precedent over which medicine could never win.

▶ Dr. Anderson, P.O. Box 1089, Ocala 32670.

Ocular Problems of the Elderly

Cecil C. Beehler, M.D.

Modern medicine has increased greatly the number of individuals living long beyond the usual retirement age of 65. Due to Florida's many attractions for the retired, medical practice in many instances becomes largely geriatric. For this reason it is important for all of us to recognize the ocular problems common to our elderly patients.

While elderly patients are subject to all the ocular problems of younger patients, certain diseases afflict primarily the aged. Degenerative disorders constitute the bulk of these problems; however, neoplasms, vascular accidents and certain infections take on increased importance in later life.

Cataracts

Few conditions as common as cataracts are so poorly understood. While every lens opacity is technically a cataract, only opacification sufficient to cause significant impairment of vision is important. The crystalline lens becomes increasingly less transparent in all of us with age. The evidence indicates that practically every individual would develop cataracts if he lived long enough, but the age at which they develop shows wide variation.[1] In some cases, the early occurrence of cataracts is unquestionably an inherited trait.

The treatment for cataracts is surgical. Modern techniques have made cataract extraction almost always a safe and successful therapy. Improved sutures and instruments enable the surgeon to close the wound tightly, so that patients rarely are required to remain at bed rest for more than a day or two. The proper time for surgery depends upon the individual's need for good vision. Bilateral surgery, appropriately spaced, should be recommended for all patients who have had normal binocular vision in order to maintain the advantages of binocular vision and to avoid the confusion that frequently results from the presence of a remaining clouded eye.

Glaucoma

Glaucoma consists primarily of two distinct types of disease processes which are similar only in that the intraocular pressure is elevated. They differ completely in pathophysiology and in treatment. Acute congestive narrow angle glaucoma is caused by apposition of the iris to the cornea, causing a sudden and severe elevation in pressure. It occurs only in individuals predisposed to angle closure by anatomic narrowness of the chamber angle. In this condition there is a rather sudden onset of headache, severe eye pain, blurring of vision, nausea and vomiting and often profound prostration. The cornea is hazy and the iris is fixed in mid position. There is marked hardness of the globe which may be detected by finger palpation. Acute congestive glaucoma is a major emergency in ophthalmic practice. If the pressure is not normalized rapidly, severe visual loss will occur. If treated promptly, the pressure usually responds well to topically instilled miotic agents such as pilocarpine and carbachol. Further reduction in pressure may be accomplished by parenteral administration of acetazolamide, mannitol or orally administrated glycerol. Once the pressure is controlled, iridectomy provides an effective cure.

Chronic simple or open angle glaucoma is, in some ways, more dangerous than angle closure glaucoma. In this disease the pressure elevation is small and can be detected only by direct measurement of the intraocular tension. The chronically elevated pressure results in atrophy and cupping of the optic nerve, which in turn causes a progressive constriction of the visual field. Central vision is preserved until last, accounting for the fact that few or no visual problems are encountered until advanced stages of the disease. Vision lost to glaucoma is irreversible. This form of glaucoma usually responds well to medical treatment.

Glaucoma is one of the leading causes of blindness in the United States. The incidence of glaucoma in the population above age 40 is at least 2%.[2] Since the blinding potential of this group of diseases can be greatly reduced by early diagnosis and treatment, it is important for all practitioners of medicine to be alert for undetected cases.

Retinal Degenerations

The visual acuity of elderly people often deteriorates even in the absence of specific eye disease. This deterioration of vision corresponds to senile changes of other bodily functions. A reduction in visual acuity to 20/40 in a healthy individual 75 years of age is not unusual. The fundus may appear normal except for the usual changes in blood vessels due to arteriosclerosis and some stippling and pigmentary changes in the macula. Since the activities of the elderly often are sedentary and call for close work, poor vision is annoying and is a frequent cause of complaint. A strong reading lens and powerful illumination provide the only relief that can be offered.

Senile macular degeneration is a more serious disorder. Unfortunately, this is a relatively common disease and is a degenerative process, usually bilateral, which occurs in the macula. For the most part, it is limited to this area and the surrounding retina looks healthy. Many cases show only minimal changes when observed with the ophthalmoscope, the changes consisting of pigmentary spots and a moth-eaten appearance of the macula. In more severe cases, hemorrhages, areas of atrophy and pigmentary migration obliterate the macular area. Although macular degeneration takes different forms, all probably have atheromatous changes in the retinal and choroidal circulation. Patients with this disease may lose completely their ability to read and do fine work, but never lose peripheral vision. These patients can be assured they will not "go blind," but must be encouraged to seek activities which do not require sharp vision. Severe retinal disease, which can lead to total blindness, frequently is encountered in connection with diabetes and hypertension.

Neoplastic Disease

The basal cell carcinoma is the most common malignant tumor of the eye lids, occurring in over 90% of cases.[3] This lesion occurs most commonly on the lower lid or inner canthus of the eye. The tumor usually presents the typical appearance, with smooth pearly margins and dilated blood vessels. The appearance may take on many forms, however, so that any enlarging growth of the lid should be excised or biopsied. Since basal cell carcinomas do not metastasize, this disease readily can be cured with adequate surgery. When the tumor is large, or located in essential tissue, however, surgical repair of the defect is challenging.

The only tumor of the globe which occurs frequently enough to warrant discussion here is malignant melanoma. In the globe, this tumor ranges from a nearly benign course to one which is highly malignant, depending on the cell type. The tumor often causes retinal detachment with resulting loss of vision, but also may present as a unilateral glaucoma or cataract. Since these tumors often are trapped within the globe until the disease is well developed, surgical removal frequently results in a cure.

Degenerative Lid Problems

Ectropion is caused by loss of elasticity of the eyelid due to senile degenerative changes of the tissue. The lid sags, resulting in pooling of tears and chronic infection. The chronic irritation causes the patient to wipe the eye frequently, aggravating the condition. Entropion has a similar etiology; in this condition, however, the lid is turned inward, forcing the lashes against the globe. The cornea is ill-equipped to tolerate such abuse, and frequently the epithelium erodes and ulcers appear. These conditions are a common cause of ocular complaint in the elderly, but fortunately both respond well to surgery.

Trichiasis is a troublesome and potentially dangerous lid problem. Chronic blepharitis or lid infections distort the lash follicles, causing many of them to press against the cornea and causing the same symptoms and complications as spastic entropion. This condition may be relieved by electrolytic destruction of the hair follicles.

Keratoconjunctivitis sica is characterized by a decrease in tear production as well as a decrease in lysozyme content of the tears.[4] Lysozyme is a proteolytic enzyme of the tears. This condition usually appears in menopausal women and is accompanied by a decrease in function of the lacrimal glands which leads to dryness, redness and irritation of the eye. Rolled filaments of epithelium may form on the cornea and a dry, stringy exudate collects in the conjunctival sac. Diagnosis usually can be made with filter paper analysis of tear production, or by the marked staining of the conjunctiva and cornea with Rose Bengal dye. Symptomatic relief may be obtained with artificial tears in mild cases, but more severe cases may require destructive cautery of all four puncta in order to conserve all lacrimal secretion that is present.

Infections

Herpes zoster ophthalmicus is a severe painful condition caused by a virus infection of the gasserian ganglion. Ulceration and pain occur along the distribution of the first and second branches of the trigeminal nerve. The disease always is limited to one half of the face and shows a characteristic sharp demarcation in the midline along the brow and nose. Patients frequently complain of severe pain, photophobia and tearing of the affected eye several days prior to the outbreak of the vesicles. By the time vesicles appear, the skin is red and swollen. If the nasociliary nerve branch is involved, severe uveitis may occur.[5] Corneal sensation is reduced, making neuroparalytic keratitis a definite danger. On the lids the vesicles appear along the course of the frontal, supratrochlear and lacrimal nerve. The treatment of zoster is frustrating and difficult, as no specific therapy is available. Primary considerations are prevention of secondary infection and relief of pain.

Vascular Accidents

Occlusion of the central retinal artery results in a dramatic rapid and complete loss of vision. The loss is usually total and permanent. The obstruction may be spastic, thrombotic or embolic in origin. If seen with the ophthalmoscope in the early stages, the arteries are reduced to thin threads or are invisible. The veins appear more normal, but no venous pulse is present. Within a matter of hours the retina loses its transparency and becomes milky white. The thinness of the retina in the macular area allows the color of the choroid to show through, giving rise to the characteristic "cherry red spot." After a number of weeks the edema gradually subsides, the cherry red spot disappears and the only remaining evidence of the damage is the narrowed vessels and an atrophy of the optic nerve. In order to have any chance of success, therapy must be started within an hour of the occlusion. Treatment is directed towards dilation of the artery and the prevention of blood clot. Occasionally, massage of the globe helps to pass an embolus farther down the artery, thereby minimizing damage. For vasodilation, inhalation of amyl nitrate or subcutaneous or retrobulbar injection of acetycholine (0.1 to 0.2 gm.), papaverine (0.03 gm.) or atropine may be tried.[6]

Venous Occlusion

Occlusion of the central vein presents a dramatic and characteristic picture as viewed by the ophthalmoscope. The entire fundus is filled with diffuse hemorrhages, yellow and white exudates and edema. The retinal veins are enormously engorged and tortuous. These occlusions, however, may be gradual in onset and incomplete, so the visual loss is often less severe than with arterial occlusion.

The prognosis for central vein occlusion is poor, and a recalcitrant hemorrhagic secondary glaucoma may develop in the affected eye—a distressing complication which is not controlled with the usual glaucoma medications. The eye often becomes so painful that removal of the eye is essential to relieve the patient. This complication occurs in some 20% of cases of central venous occlusion. Anticoagulant therapy should be tried in all early or incomplete cases of venous occlusion, as it is the only therapy which offers any hope of benefit.

Small Strokes

Perhaps one of the most annoying ocular disturbances seen in the aged is diplopia caused by muscle palsies as a result of vascular accident of the third, fourth or sixth nerves. The defect may be manifest only in certain directions of gaze, but in severe cases is constant and accompanied by gross paralytic strabismus. Careful evaluation of the extraocular movements and study of the diplopia fields usually isolates the offending nerves and helps to locate the lesion within the brain stem.

Treatment is directed toward the primary disease process. Diplopia and confusion can be eliminated by merely covering one eye. The patch should be alternated to minimize contraction of the antagonist since some return of function is obtained in most cases. If good binocular function is not obtained, surgery on the extraocular muscles may give improvement.

References

1. Gordon, D. M.: The Eye—65 and Over, Brochure from New York Hospital.
2. Roberts, W.: Ocular Problems in Geriatric Practice, The Older Patient, New York, Paul B. Hoeber, Inc. p. 134, 1960.
3. Hogan, J. H. and Zimmerman, L. E.: Ophthalmic Pathology, Philadelphia, W. B. Saunders Co., p. 212, 1962.
4. Duke-Elder, S.: Systems of Ophthalmology, St. Louis, The C. V. Mosby, Co., 5:8, pt. 1, 132, 1965.
5. Adler, F. H.: Gifford's Textbook of Ophthalmology, Philadelphia, W. B. Saunders Co., p. 158, 1957.
6. Duke-Elder, S.: Systems of Ophthalmology, St. Louis, The C. V. Moshy Co., 10:104, 1967.

▶ Dr. Beehler, 1542 Carson Street, Fort Myers 33901.

Diabetes: Diagnosis by Retinoscope

Nathan S. Rubin, M.D.

The excitement in diagnosing diabetes is felt by the student when the gas flame has changed the color of the urine-chemical mixture in his test tube to a yellow-green. Drama occurs when microaneurysms are seen in the retina with the ophthalmoscope, or when complications have caused the loss of a limb. All these reveal—rather late—the entity of diabetes which then becomes a condition of dire implications for the patient.

The diagnosis of diabetes allows a fairly hopeful prognosis if it is made early when the course of the disease may be influenced; it becomes catastrophic if it is made so late that complications are in prospect. There is no challenge in discovering diabetes upon the finding of positive test results on urine, when polyuria, polydipsia and polyphagia are present, or when retinopathy is about to add another number to the statistics of the blind. By then the diabetes has long been present and awaiting recognition.

Diabetes may begin at birth or it may remain latent and become overt when provoked by the long-time stresses of aging or obesity, or by the acute stresses of infection or pregnancy. During this course, there is a prediabetic stage[1] in which no abnormality of carbohydrate metabolism is demonstrable until the individual is exposed to a sufficiency of stresses, and a subclinical stage[2] in which the diabetes exists but is undetected. These patients frequently go to the ophthalmologist for routine care of disturbances in ocular function that are usually resolved by correction of refractive errors with lenses. It is this prosaic eye examination for glasses that may suggest the possibility of diabetes and the need for specific laboratory tests.

Suspicion is aroused when the retinoscope reveals a marked change in the error of refraction as compared to previous records or to the lens prescription the patient is currently wearing. This difference usually is unexplainable, is not accompanied by retinal changes and is found in persons who are not suspected of having diabetes. These patients, when subjected to a glucose tolerance test, frequently exhibit hyperglycemia, with or without glycosuria. In this stage protective programs yet can be initiated to reverse the course or prevent the later clinical manifestations.

Changes in refraction due to diabetes frequently have been noted since they were first described by Rosenstein (1858) and by Horner (1873). The essential features are a relatively sudden and bilateral change in the amount of refractive error, usually an increase in myopia. When this happens without any explanation, it should make the patient a diabetes-suspect to be proved or disproved by specific laboratory testing. When occurring in a known diabetic, it suggests a laxness in control.

The specific cause of this change in refraction is yet to be conclusively demonstrated. Several hypotheses indict changes in the accommodation, in the ciliary processes, in the axial diameter of the globe because of increase or decrease in intraocular fluids or in changes of the refractive index of the aqueous or vitreous. A more satisfactory explanation would implicate the lens in the diabetic process ever since Elschnig (1923) reported refraction changes only in the phakic eye of a diabetic with unilateral aphakia.

Duke-Elder (1925)[3] postulated that the myopia associated with hyperglycemia was due to hydration of the cortical layers of the lens, while Granstrom (1933) suggested that the hydration occurred in the lens nucleus. As the blood glucose level rises there is retention of saline in the tissues, the osmotic pressure decreases and, in order to establish equilibrium with the aqueous, fluid flows into the lens to create swelling and changes in curvature. The refractive power of the eye is thereby increased and the eye becomes myopic. When there is a fall in the blood glucose concentration, a reverse osmotic flow occurs that is followed by hypermetropia and the return of the eye to its customary refractive condition.

A transitory myopia also may occur in the presence of incipient cataractous changes, from

the administration of miotics, from such drugs as arsenicals and sulfonamides, from toxic diseases and from radium irradiation. When conditions such as these are not present to explain an unusual increase in myopia, the ophthalmologist who is alerted to the possibility often can help in the diagnosis of diabetes before it has gone into the acute or chronic stage. When the patient complains of a bilateral loss of distant vision and yet finds he reads better without his glasses, think of diabetes.

Report of Cases

Case 1.—A 58-year-old white man presented with blurred distant vision, especially in the right eye, relieved only temporarily with two changes in lens prescription in two years. He was wearing: OD: −2.50 + 3.75 x 90 = 20/40; OS: −0.25 + 1.75 x 93 = 20/25. He required: OD: −3.25 + 1.75 x 90 = 20/20; OS: −0.50 + 1.75 x 98 = 20/15. Other eye examination, including tension, media and fundi were normal. His glucose tolerance test was:

Fasting Blood	104 mg./100 cc.	Urine Neg.
½ Hour	126 mg./100 cc.	Neg.
1 Hour	215 mg./100 cc.	1+
2 Hours	206 mg./100 cc.	4+
3 Hours	130 mg./100 cc.	2+

Refraction has remained stable since diabetes control.

Case 2.—A 60-year-old white woman complained of decreased far vision, worsening rapidly from October to March. She was wearing: OD: −0.25 = 20/50; OS: −0.25 −0.50 x 60 = 20/50. Improved to 20/20 in each with OD: −1.00 −0.50 x 130, OS: −0.75 −0.75 x 60. She returned in five months because her distant vision was reduced to 20/50 in each eye. Tension, media and fundi were normal. Her new refraction was OD: −1.75 −0.50 x 145 = 20/20; OS: −150 −0.75 x 70 = 20/20. Her glucose tolerance test was:

Fasting Blood	119 mg./100 cc.	Urine Neg.
½ Hour	201 mg./100 cc.	Neg.
1 Hour	231 mg./100 cc.	Neg.
2 Hours	210 mg./100 cc.	Neg.
3 Hours	137 mg./100 cc.	Neg.

Refraction has remained stable since diabetes control.

Case 3.—A 59-year-old Negro woman complained of difficulty with far vision, worsened by present glasses which were only three months old. Vision OD: 20/50, OS: 20/50; vision with old correction (+0.25 +0.50 x 180 OU) was 20/70 OU. Manifest refraction improved vision to 20/20 in each eye with OD: −0.75 −0.25 x 10, OS: −0.75 −0.25 x 170. Fundi, media, tension and other eye examinations were within normal limits. The glucose tolerance test was:

Fasting Blood	110 mg./100 cc.	Urine Neg.
½ Hour	148 mg./100 cc.	Neg.
1 Hour	227 mg./100 cc.	1+
2 Hours	219 mg./100 cc.	1+
3 Hours	130 mg./100 cc.	Trace

Manifest refraction one month later was OD: +2.25 +1.00 x 95 = 20/20; OS: +3.00 +1.00 x 60 = 20/20, add +2.00, indicating that there was now over-control.

Summary

In diabetes, the earlier the diagnosis the better the prognosis. Sudden changes in refraction, usually an increase in myopia, may be a clue to subclinical diabetes. Results from a glucose tolerance test often are revealing.

References

1. Camerini-Davalos, R. A., Caulfield, J. B., et al: Preliminary Observations on Subjects with Diabetes, Diabetes 12:508, 1963.
2. Krall, L. P.: When Is Diabetes? Med. Clin. North America 49:893, 1965.
3. Duke-Elder, S.: Textbook of Ophthalmology, 4:4364-4367, St. Louis, The C. V. Mosby Co., 1949.

Dr. Rubin, 1401 North Palafox Street, Pensacola 32501

The Eye and Whiplash Injuries

William J. Gibson, M.D.

Whiplash or, better expressed, extension-flexion injuries usually are incurred in rear-end collisions where one vehicle impacts another which is actually, or relatively, at a standstill. Forceful and rapid extension of the neck occurs backwards which stops only when the occiput impinges on the dorsum or a surface within the passenger envelope. Usually secondarily, there follows forward flexion, the extent of which is limited by the chin hitting the chest or a surface in the front of the passenger compartment.

Mild to severe neck damage may occur from fracture dislocations of the vertebrae with or without spinal cord injury, compression fractures of vertebral bodies or fractures of the spinal processes and laminae to rupture of the intervertebral discs and intervertebral ligaments and/or tears of the anterior or of the posterior long ligaments of the vertebrae. Severe damage may be present with no x-ray evidence of derangement.

The belief is widely held that these are "simple sprains" which will resolve with time and resolution of the attendant litigation. Most physicians and defense lawyers imply that the complaining patients are either neurotics or malingerers who are presenting a case of litigation neurosis for consideration. In the cases with demonstrable findings it is remarkable how seldom there are complaints of the frequently associated injuries.

A considerable body of literature has been published on this problem from the fields of orthopedics, neurology, physical and industrial medicine, ophthalmology and, most prolific of all, legal medicine. The latter category unfortunately is often colored by the economic responsibility of the author to the litigants.

In the field of orthopedics, Janes[1] described the pathology found in 31 cases of whiplash injury which came to spinal fusion for the relief of symptoms. This, for the most part, consisted of hypermotility of spinous processes, laxity of the posterior ligaments, rupture of the interspinous ligaments, fraying of the supraspinous and infraspinous ligaments, rupture of the Ligamentum Nuchae and calcification of many of these tissues.

Dr. Gibson is clinical associate, Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

McNabb[2] produced all grades of cervical injuries in monkeys by sled experiments, developing various inertial forces on the neck region.

Newman and Biluk[3] conclusively showed by electromyography that these victims interpret muscle spasm as pain. Torres and Shapiro[4] showed by serial electroencephalograms that there can be significant EEG changes in whiplash injury. Ommaya[5] recently reported experimental concussion in monkeys by inertial forces limiting body deformation to whiplash effect alone, carefully protecting the head and the rest of the body.

In the field of ophthalmology, DuPont-Guerry[6] and Horwich and Kasner[7] described ocular dysfunction associated with extension-flexion injuries.

The anatomic and physiologic basis for ocular dysfunction in extension-flexion injuries was established as far back as 1850, when Luska[8] described the sinuvertebral nerve. This is a sensory nerve derived from the spinal root ganglion and autonomic chain which innervates the posterior longitudinal ligament, the capsular structures and the surrounding ligaments of the cervical tissue. Kaplan[9] in 1947 described the recurrent meningeal nerve. This supplies sensation to the cervical area, is segmental in origin and arises in the spinal canal. Its larger branch, going to the venous plexuses, is joined by the superior cervical sympathetic chain and enters the posterior sensory root of the next spinal nerve. Newman and Biluk[3] confirmed the findings of Cloward[10] that he was able to localize pain and its distribution in the neck by direct needle and electrical stimulation of the anterior and posterior longitudinal ligaments and the annulus fibrosis, in the conscious and unconscious subjects. "The sinuvertebral nerve receptors are in the peripheral fibers of the annulus fibrosis, are also attached to the margins of the adjacent vertebral bodies and supply one half of the disc, decussating across the midline, proceeding to the spinal cord, anterior nerve root, and by the effector nerve to the vertebral border of the scapular muscles."[10]

The ciliary ganglion, mediating convergence, accommodation and the pupillary responses have

motor connections with the third nerve; a sensory root (branches of the nasociliary nerve from the fifth cranial nerve) approaches the globe as the long ciliary nerves, and has sympathic fibers from the cavernous plexus which may be traced to the superior and middle cervical sympathetic ganglia.

Horwich and Casner[7] reported ocular findings associated with extension-flexion injuries of the neck. They described symptoms as inability to focus upon objects far or near, diplopia, irregularities of the pupils, aching of the eyeballs and inability to read for more than a few minutes at a time. They believed the findings explicable by the fact that the base of the brain was more vulnerable to sudden motions when forced against the unyielding skull because of the numerous fine nerve structures in this area.

DuPont-Guerry[6] described accommodative impairment associated with extension-flexion injuries in numerous cases seen in a Richmond general hospital.

This report covers ten cases seen for evaluation in litigation in which only three presented demonstrable objective findings.

Report of Cases

Case 1.—A 38-year-old woman was injured in an overtaking accident. She complained of ocular pain and diplopia from the day of the accident. She showed exotropia of 25 prism dioptors for near and a remote near point of convergence. Her near point of accommodation measured 430 and 400 millimeters in the right and left eyes respectively. She could overcome only one prism dioptor base out and five base in. She was made comfortable with a plus 1.00 add and a 6 dioptor prism base in, for near only. Thirteen months after the injury she showed exotropia of 18 for near.

Case 2.—A 20-year-old woman was involved in an overtaking accident and from the day after the accident presented complaints of visual hlurring, mostly for near and worse with fatigue, a feeling of poor depth perception so that she felt unsafe driving and ocular discomfort with any near use of the eyes. Pertinent findings were exophoria for near of 10 prism dioptors in the primary position, increasing to exotropia of 18 prism dioptors in upward gaze and decreasing to 8 in downward gaze. She could overcome 4 prism hase out in the primary position. Her near point of convergence suhjectively was 240 millimeters and ohjectively was 150. She presented a "walking" near point of accommodation in the right eye, with blur first occurring at 280 millimeters and on successive tests (5) was steady at 470. The left eye was 350 to 490 on similar tests.

Case 3.—A 52-year-old woman was in a rear end collision and hospitalized for 25 days. Her symptoms date from the day of the accident. She complained of pain constantly behind hoth eyes associated with daily severe left hemicrania. She also complained of the left upper eyelid drooping almost constantly and worse as the day wore on. She could not read or watch television because of her ocular pain. Both pupils had normal responses and vision corrected to 20/20, with normal near point for her age. The interpalpehral fissure measured 11 millimeters on the right and 8 on the left. There was some levator weakness on the left as shown by lid lag and inahility to open as widely on the right. Positive findings were, weakness of the left levator paplebrae muscle and tenderness across the distribution of the left supratrochlear nerve. Malingering was disproved by testing with plus lenses and producing expected near points of accommodation.

Of the other seven patients, three were proven malingerers who described the same visual field at two meters as at one meter and who expressed their color fields the same as for white.

The four remaining cases had multiple subjective symptoms but none that could be objectively demonstrated in relation to ocular function. They also, for the most part, complained as bitterly of any associated injuries as they did the one which might be related to neck injury.

Summary

Several cases are presented with proven objective ocular dysfunction following extension-flexion whiplash injury to the neck, with pertinent review of the literature which may explain these findings. The findings are: (1) pain and tenderness about the eyes; (2) weakness of convergence; (3) exophoria or exotropia at near; (4) paresis of accommodation; (5) impaired depth perception; (6) ptosis; (7) pupillary abnormalities, and (8) asthenopia.

It is hoped this paper may help prevent injustice to the many victims of rear end collisions who, as a result, have real disabilities.

References

1. Janes, J.: Proceedings, American Association for Automotive Medicine (Oct. 26-27) 1964.
2. McNabb, I.: Proceedings, American Association for Automotive Medicine, Rochester, Minn., (Oct. 22-23) 1965.
3. Newman and Biluk: Proceedings, American Association for Automotive Medicine, Louisville Ky., (Oct. 26-27) 1964.
4. Torres, F. and Shapiro, S. K.: Brain Injury Complicating Whiplash Injuries, Minnesota Med. 43:473-476 (July) 1960.
5. Ommaya, A. K.: Stapp Crash Conference, Anaheim, Calif., 1967.
6. DuPont-Guerry: Virginia Med. Month., 89: 165-168 (Mar.) 1962.
7. Norwich and Kasner: Southern Med. J., 55: 69, 1962.
8. Lushka, H.: Die Neren des Menschlichen Wierbelknales, Tubigen 1859 (Quoted from Newman and Biluk).
9. Kaplan: Recurrent Meningeal Branch of Spinal Nerves, Bull. Hosp. Joint Dis. 8:108, 1947.
10. Cloward, R. B.: Clinical Significance of Sinu-vertebral Nerve of Cervical Spine in Relation to Cervical Disk Syndrome, J. Neurol. Neurosurg. Psychiat. 23:321-326 (Nov. 6) 1960.

▶ Dr. Gibson, 168 Marine Street, St. Augustine 32084.

Recent Advances in Cataract Surgery

Thomas S. Edwards, M.D.

How many physicians remember the arduous time the cataract patient had 15 or 20 years ago? How many remember the sandbags on both sides of the head while the patient lay flat in bed for two weeks? How many remember the strokes and pneumonia complications in the elderly patient because they lay so inert? How many remember the binocular patches that kept the patient in total darkness and frequently caused disorientation? Fortunately, this is no longer necessary. The ophthalmologist neither has to keep the patient quiet for two weeks, nor does he have to wait for the cataract to ripen while the patient gets progressively worse.

Thanks to many new advances, the cataract operation may actually be easier on the patient than an adenotonsillectomy. Recent advances can be grouped into four main categories: (1) Preparation of the patient prior to surgery; (2) New equipment and sutures available for surgery; (3) New techniques used in surgery, and (4) New follow-up techniques after the operation is completed.

Preparation

In considering preparation we must include the close cooperation of the family physician, general practitioner and internist, who make the job easier by having the patients in excellent health. Often they determine a possible cause of the cataracts if they are known to be secondary to other than senile causes. If the patient is not in excellent health, the family physician employs his own therapy for control such as cardiovascular, diabetic and/or other medications, increasing the confidence of the surgeon. Previously it was thought that preoperative antibiotics were of assistance in decreasing infections; however, antibiotics given now at the time of surgery and immediately following do an excellent job in preventing secondary infection. In evaluating the patient, recognizing the fact that certain types of body details make for more complicated cataract operations has aided in improving our results. The short, full-necked, stocky patient usually is a more difficult candidate for surgery than the average lean-necked slender patient. Extra effort must be brought about to lower the intraocular pressure in the former patient. Special preoperative techniques must be used to lower elevation of this pressure. Manitol, dextrose, or glycerine sometimes are given to lower the intraocular pressure, and Diamox frequently is given the day before and the day of surgery for the same results.

Ocular massage is used at time of surgery to assure low intraocular pressure. Another factor in improving our results is the recognition by many ophthalmologists that the complications found in one eye frequently will be the problems you will encounter in the other eye. Accordingly many schools of thought recommend that one eye be operated upon and observed closely until it is completely healed before the second eye is operated upon. This seems to improve the results on the second eye if complications occur as a result of operating on the first eye.

New Equipment

New equipment, the second category, greatly affects the third category of new techniques. Some very fine operating microscopes have been developed (Fig. 1), permitting the surgeon to work through a 10-power microscope, easily observing his technique of cataract surgery so that the sutures may be placed exactly where he wants them. This leads us to one of the biggest advances in cataract surgery in the last 20 to 30 years. New, extremely fine, sharp needles have been developed which are used on new types of sutures. A 7-0 chromic catgut has been developed, as well as an 8-0 collagen suture and 8 and 9-0 virgin silk sutures. All of these sutures are so fine that, using the extremely fine, sharp needle, they easily can be placed in the middle third of the cornea and can be left in the tissues. Catgut sutures and collagen sutures will dissolve and fall out and the virgin silk sutures usually give no reaction and can be left in.

Of much greater importance to the recent advances in surgery are some of the medications

Dr. Edwards is clinical associate, Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

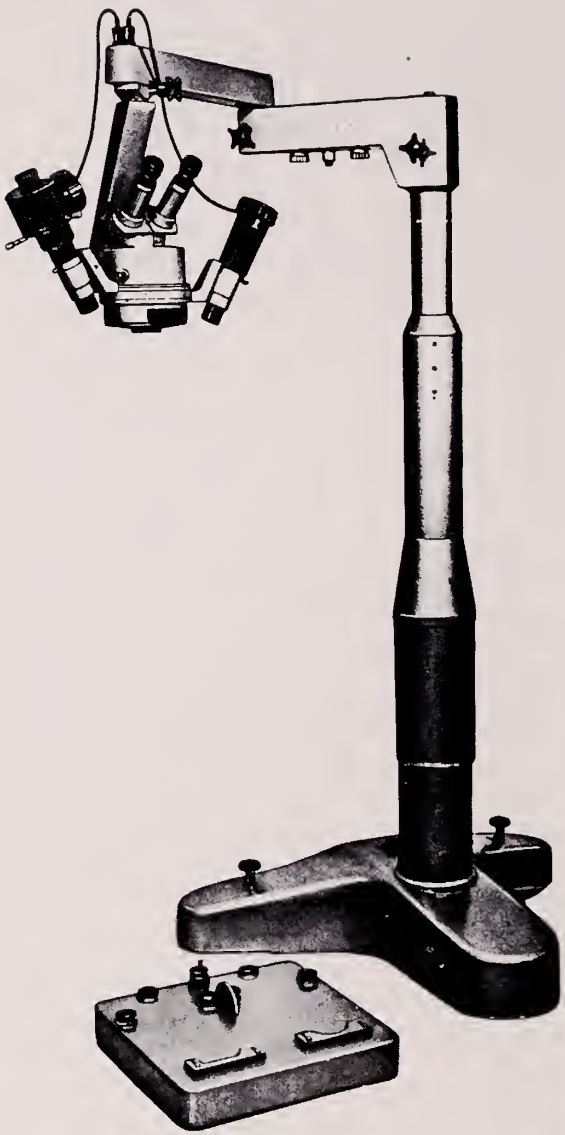


Fig. 1. — New operating microscope.

now being used. The new local and general anesthetics give much better control of the patient and this has aided ophthalmologists in cataract surgery. Of special interest is the drug alphachymotrypsin which has revolutionized cataract surgery for certain patients. This is an enzyme which can be injected into the anterior chamber and will dissolve the zonules holding the lens in place. In a normal patient under 50, the zonules are rather tight and it takes a great deal of technical skill to break them. With the alphachymotrypsin, the zonules can be dissolved and it becomes easier to surgically deliver the cataract in a young patient. Some eye surgeons use alphachymotrypsin in all cataract surgery.

Another step forward is the use of miotic agents, such as acetylcholine and pilocarpine after the operation to pull the iris sphincter muscle tight and make a very small pupil. This is beneficial in two ways. First, it keeps the iris from prolapsing if, for instance, the wound should reopen in the first 24 hours and, secondly, it also holds the vitreous face back and protects the hyaloid membrane. It is known that if the vitreous body can be kept intact, the complications from cataract operations are decreased tremendously. Another advance is the equipment used to deliver the cataractous lens. In days past, we used a forceps to hold the lens. Next came a small suction instrument called the erisophake (suction cup) to deliver the lens. In recent years, mechanical erisophakes have been developed which hook on to suction pumps that enable better mechanical delivery of the lens. In addition, freezing (cryo) probes have been developed which freeze the lens to a probe (Fig. 2). The lens can then be delivered without applying the pressure and suction that the erisophake and forceps apply. The cryoextractor has been of great assistance in delivering hypermature cataracts, since the capsule of these cataracts frequently ruptured when using the older instruments.



Fig. 2. — Cryoprobe with hypermature lens attached.

New Techniques

Many of the older physicians will remember the days when a cataract operation was done in two and three stages. Fortunately, in the last 20 to 25 years, intracapsular cataract extractions are done in one stage. The effect of this is obvious; the convalescence is greatly decreased and the patient is submitted to the trauma of surgery only once instead of the two or three times per eye. The increased surgical skills in making the corneal-scleral incision, as well as the increased skill of suturing the corneal-scleral incision in almost

perfect apposition, is one of the biggest factors in the improved results of cataract surgery and the decreased convalescence. In not too many years past, the corneal-scleral incision was made and either no sutures were placed or one or two sutures were placed to hold the eye together. Now the sutures may be placed in a groove in perfect apposition before the eye is completely open. The corneal incision may be a groove or a corneal step-type incision and there usually is perfect apposition of the corneal-scleral incision into its bed. The fine needles and sutures previously mentioned make it possible to put from three to 11 sutures in the corneal-scleral wound, bringing about perfect closure. The ocular microscope (Fig. 1) also aids in the perfect placing of the sutures and perfect apposition of the corneal-scleral incision. With these improved techniques, it has become obvious that a wider incision aids in ease of delivery of the cataractous lens. Accordingly, the incision is almost always 180 degrees and sometimes as much as 200 degrees of the corneal diameter. With this, the cornea is traumatized less when it is pulled up to deliver the cataractous lens, and is more likely to remain completely clear. The new type erisophakes and cryoprobes are found to be much easier to use with the wider incision and less trauma is actually done to the eye with some of these instruments. The antibiotics also have been a big step forward and are used in almost all cataract operations, either at time of surgery or for the next two or three days. This has greatly decreased the role of secondary infections and morbidity.

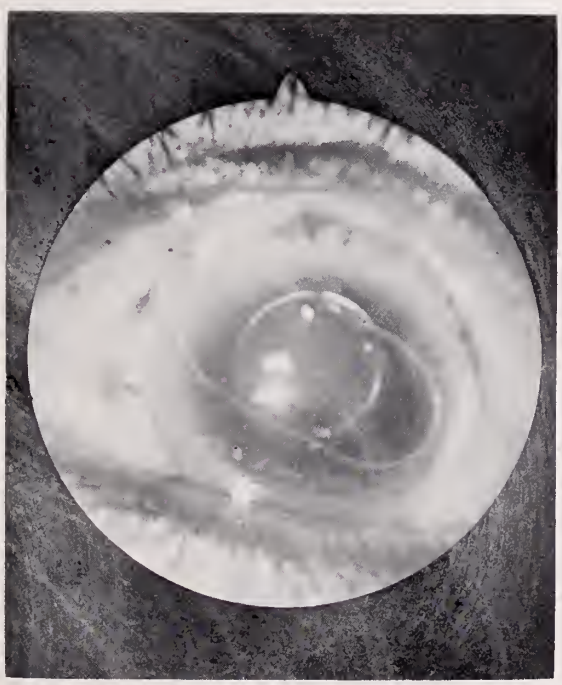


Fig. 3.—New intraocular lens inside the pupil and anterior chamber of the eye (courtesy of Dr. Herve M. Byron, New York Eye and Ear Infirmary, New York, N. Y.)

Two techniques still in the experimental stages which should be mentioned, as they will affect cataract surgery greatly in the near future, are office cataract surgery and intraocular lenses. Several papers have been published relative to doing cataract operations in the office. These, of course, are offices of large ophthalmological practices with well equipped operating rooms. The patients are then sent home, to a nursing home or, occasionally, to a hospital. The results appear to be good and the complications may be even less with operations performed in the office than those resulting from operations done in the operating room. Of course, studies are as yet too small to be conclusive. Recently, one of the larger medical centers, New York Hospital—Cornell Medical Center, began sending their cataract patients home the day following surgery. The effect that this will have on hospital beds is obvious to all and the results are being expectantly watched by all interested ophthalmologists.

The other advanced technique which is being expectantly watched is the intraocular lens. Patients having a cataract on one eye and a normal second eye have a difficult time with binocular vision. Intraocular lenses which will give good binocular vision are being developed. The Ridley lens which was placed just behind the iris was one of the first. This has been followed by the Strompelli lens, which is placed in the anterior chamber. Both of these brought about a number of complications. Some new lenses, placed in the pupil and just behind the pupil, appear to be more successful and are held in place by clips on both sides of the iris (Fig. 3). In one group, no apparent complications have occurred with these intraocular lenses in place for ten years; for a limited segment of cataract patients, this may be a major advancement in the near future.

Follow-up

Due to the fine sutures now used, patients usually are out of bed the day of the operation or the following day and are not kept flat on their backs with sandbags for two weeks, as once was necessary. Most patients are out of the hospital in five to seven days after the operation; this is a big step forward in releasing hospital

beds from the customary two weeks' stay. Releasing the patient the day after surgery, or even performing the operation in the office, has a tremendous beneficial effect on the hospital bed shortage.

In the optical field, early visual aids are available which permit the patients to have temporary glasses fitted five to ten days after surgery, thus increasing ambulation. Some patients, with the aid of temporary optical aids, actually are reading two to three weeks after being operated upon.

With the new advances in techniques and instrumentation that have been developed in cataract surgery, it is no longer the feared operation that it once was. This is important when we consider that all of us, if we live long enough, will develop cataracts leading to surgery in our seventh, eighth or ninth decades of life.

▶ Dr. Edwards, Suite 453, Marshall Taylor Doctors Building, Jacksonville 32207.

Contact Lenses: Their Place in Medicine Today

Frederick E. Hasty, M.D.

It is told that two German scientists cut off the rounded end of test tubes, shaping the pieces of glass so that they could be tolerated in the eye for a few hours at a time. They hoped that such lenses would press and hold back the protrusion of the cornea in what is known as keratoconus. Thus the start of contact lenses.

After many years came the great wave of the use of contact lenses when it was discovered that a plastic, methyl methacrylate, could be used to make a lighter, thinner and safer contact lens. The public became overly enthusiastic, saying, "Spectacles will soon be a thing of the past."

Following the excessive enthusiasm and the inevitable problems that followed in its wake, a public reaction set in, causing a drop in contact lens popularity. Smaller waves of alternating upsurge and retreat followed until at present, a proper place for these lenses is becoming established.

Cosmetic and Psychological Prescribing

The majority of contact lenses are prescribed for cosmetic and psychologic reasons, especially among teenagers.

A child psychologist refers teenagers for eye tests with the request not to give glasses. Contact lenses often are the key to composing a frustrated child.

A husky boy bolts into our private office and asks, "Is this the place one can get contact lenses? I must play football." Report from his parents later: "Our son had become impossible; now he's a perfectly normal boy."

A doctor's two lovely daughters had become very disagreeable in the home and at school; they were socially tolerated but not pressed to the main social group. They obtained contact lenses before the next school term. From school, they came yelling, "Mom, guess what, so and so asked for a date." Grades improved.

Improvement in Sight

The improvement in sight with contact lenses is not limited to the straight ahead vision. The visual field is widened, in some cases more than 30%. This adds to the safety of driving. For the first time in life, the very nearsighted person may see both sides of the street. There often is an increase in depth perception. To one interested in art, the improved appreciation of shape and form add to the daily pleasures of life. A patient studying the history of art reported the contact lens "simply moved me into a new world. Now I see so many beautiful things."

Use by Athletes

Contact lenses are valuable for sports. Each spring when the baseball teams come south for training, the managers have several men tested to be sure their contact lenses are in proper order. An athlete should have at least two pairs of lenses.

Used After Injuries

Contact lenses may help eyes after injuries when glasses offer only limited benefit. Many injured employees, formerly classed as totally disabled, often may have useful and even normal vision with specially made lenses.

A man was hit in the eyes with molten metal. After five months in the hospital one eye was a total loss. The other eye, with glasses, had vision sufficient to enable him to get about in the house. The compensation board declared him eligible for total permanent disability. A specially shaped contact lens gave normal vision in the one remaining eye with sight.

A 14-year-old boy working on a farm stuck a weed in his eye; extensive scar tissue seemed to destroy all vision in this eye. Twenty years later, the good eye sustained an extensive injury. Scar

tissue blinded the second eye. A very small, specially shaped lens, fitted between parts of the scar tissue, gave normal vision in the first injured eye. He could continue in an important position.

Use Following Surgery

Following cataract surgery, contact lenses may offer much more normal vision than glasses.

One male patient had cataracts removed but encountered complications and could not regain useful vision with glasses. A specially shaped contact lens gave useful vision. He embraced his wife in ecstacy, the first time he had seen her in ten years. She was as beautiful as ever.

Contact Lenses for Children

We should not fail to report recent results in contact lenses for children. Reports have been made of good results in 3½-year-old children. A 7-year-old child was "retinoscoped" for 10 diopters of astigmatism. She could not, or would not, wear glasses which, in any case, provided little improvement in vision. A very small contact lens gave almost normal vision and the patient enjoyed the experience. In other similar cases, young children have found their vision improved through the use of contact lenses and gladly have worn them.

Japan has many children born with cataracts, totally blinding the child. Often a part or all of the "milk-like" cataract can be operated upon with success. A small 10 diopter lens is fastened in the eye for three months at a time. A Japanese doctor has informed us that it was not unusual that the child's first spoken words were to ask his mother for his "eye."

Special Lenses

Mention should be made of special lenses. The scleral lens covers the whole eye and is useful in covering unsightly eyes, usually the result of burns. Some persons can wear only the scleral lens.

Some Cannot Wear Contacts

Family physicians and pediatricians should know the previously mentioned aspects of contact lenses so they may know when to recommend them for their patients.

There are, however, some patients who are not likely to wear contact lenses with safety and comfort.

Carpenters, electricians, plumbers and mechanics of all kinds get dust, oils, fumes, heat and so forth in their eyes. Pilots make poor patients. A physician almost never learns to wear contact lenses.

People past 40 years of age seldom make good contact lens patients; however, there are some exceptions, especially postoperative cataract patients. For "socialites," first inform them about contact lenses. Patients should not attempt to develop contact lens tolerance for more than six hours at a time.

Contact Lens Fitting

There are a few points of interest to the family physician that should help him understand what the ophthalmologist considers as he progresses through the various steps of contact lens fitting.

Corneal, or "K" Reading. The crossed hairs are adjusted before each examination. Peripheral corneal readings are not dependable for accuracy, but valuable information is gained by recording findings to the nearest one-half diopter. If one side of the eye proves to be "flat," a lens should be small, 8 to 8.6 mm.

Ordering Lens. Lenses of more than 9.0 mm. in size are seldom advisable and less than 8.0 mm. are not necessary. Of all lenses ordered, 90% are 8.4 mm. to 8.6 mm. in diameter. Base curve may be made ⅛ D to ¼ D steeper than K.

Delivering Lens. One should establish a standard of quality. After thorough check of finish and dimensions, the physician should see the lens shortly after it is put on the eye. Placing one drop of anesthetic in the "bowl" of the lens, shaking out excess, will prevent excess tearing and will save the patient the shock of first insertion. The patient may develop a habit of squeezing the eye lids, throwing the head back and looking down. With light anesthetic, a prompt observation of fit can give valuable information.

Instructing Patient. A frequent mistake in contact lens failure cases is lack of instruction for wearing time and care. I have never seen a real allergic reaction to plastic. About 25% of my patients are given normal saline to be used in the full care of the lens.

The importance of so-called wetting solutions is much overrated. Some persons will show reaction to any wetting solution. Complications may be reduced by not wearing the lenses continuously (for more than 12 hours). After original corneal edema subsides, make careful adjustment. Sub-

sequent complaints should indicate the following procedure:

With "loop" at about 30 degrees from straight ahead, place floor light four feet in front of patient and observe movements of lens. Then stain. Do not depend on fluorescein. Much depends on how much solution may get underneath lens—did the patient squeeze so as to prevent solution getting beneath lens? So-called "punctate" stains likely are caused by large particles of polishing material being stuck in the lens so as to let part of the grit pierce the cornea.

Patients should be seen every second to third day until edema subsides; they are then to be seen every three months or at any time there is a change in the comfort of the lens. The patient should be taught how to clean the lens with "bird's eye" or old fashioned diaper cloth.

Cause of complaints. If the lens has been properly adjusted, there should be little if any need for further changing the shape of the lens. If repeated grinding of the lens is required, it means the lens initially was not properly fitted.

The physician should examine the patient with a slit lamp before the lenses are removed. Solid particles may be found floating in a "clump" of mucous. The particles may not be imbedded in the cornea, and washing of the lens will remove the mucous and its load of foreign material. The lens should be removed carefully so as not to touch the inside of the lens before viewing it with a radiuscope. Such viewing is a good way to study solids in cosmetics.

Be on constant watch for particles from fiberglas cloth or from many of the other synthetic cloths. Such cases usually are overlooked. Other causes of discomfort are "flattening" of the lens after several months' wear, warpage of the lens through improper handling, heating or deterioration of the plastic, hair spray and cosmetic materials collecting on women's lenses and contamination of lenses by bacteria.

Dr. Hasty, 401 Coral Way, Coral Gables 33134.

Responsibility of the Pediatrician and the Family Physician for Prevention of Blindness In the Preschool Child

Younger A. Staton, M.D.

This paper is written for physicians who undertake responsibility for the welfare of preschool children. The statements and discussions herein are of little interest to ophthalmologists; they are well aware of the problems involved.

Vision is an essential function of the developing preschool child. Educational advancement, intellectual progress and the eventual attainment of life goals depend considerably on the normal development of the visual apparatus. Any interference with the normal progress to maturity of the visual function leads to an impediment that can limit the child's future attainments.

Ophthalmologists examine many children each year that should have been seen earlier. Usually the child is referred because of failure to pass visual screening tests given in the school. Attendance at school offers the first opportunity for mass visual screening. It is unfortunate that the visual screening tests in school come too late for the successful correction of many visual deficiencies. Many of these visual deficiences should be diagnosed and treated years earlier.

Need for Preschool Visual Examinations

The eye, like so many organs in the infant, is in an immature stage of development at birth. For normal continuing evolvement, the retina and entire visual pathway must be used. Furthermore, they must be used together, in a balanced fashion, to insure normal maturation of vision in each eye and binocular vision with depth perception.

Three commonly occurring eye diseases erect barriers to the attainment of normal binocular vision:

Cataracts. Unilateral or bilateral cataracts are an obvious barrier to attainment of normal vision. In this condition, the light rays do not reach the retina or they are so irregularly refracted that normal retinal stimulation does not occur. Consequently, normal visual function does not develop. Treatment of this condition must begin at one or two years of age if any semblance of normal vision is to be obtained.

Squint or Strabismus. In this frequently occurring disease, the reasons for early diagnosis are more subtle. The straight or fixing eye may develop normally. This uniocular vision may serve the child so well that visual impediment is not obvious. What happens to the eye with strabismus? Whether it turns in, out, up or down, it is not used. Normal visual function fails to develop.

Adults who develop an ocular deviation from any cause lack the ability to suppress vision in the deviating eye and therefore suffer the great annoyance of diplopia or double vision. Children, however, can suppress the vision in the squinting or deviating eye and so avoid the annoyance of diplopia—and they do it during critical years when the eye should be developing through use.

When the eye of a child is not used, visual acuity is rapidly lost. They do not "grow out" of the condition, they "grow into" it. By five or six years of age the condition is practically irreversible.

Fortunately, successful treatment for strabismus is available. Patching or occlusion of the "good eye" can force the use of the deviating eye and obtain normal or near-normal vision in the squinting eye. An operation upon the extraocular muscles may or may not be necessary. Glasses alone may restore binocular vision in 15% of the cases. The earlier treatment is instituted, the better the final result.

Anisometropia. This is an even more subtle ocular disease which can prevent normal develop-

ment of the visual function in the preschool child. In this condition, there is a marked difference in the refractive error in the eyes. Many combinations of refractive errors exist in this disease.

Both eyes may be highly myopic or nearsighted. Without corrective lenses, neither eye will attain normal visual function.

Both eyes may be highly hyperopic or farsighted. Without corrective lenses, neither eye will attain normal visual function.

One eye may be normal or nearly normal while the other is highly hyperopic or farsighted. The eyes do not possess the ability to focus separately. In this condition, the less hyperopic eye is brought into focus by accommodation, is used and develops normally. The more hyperopic eye is continually out of focus, is not used and fails to develop normally. Many other combinations occur in this disease, but these examples will serve to indicate the problem.

Here again, the earlier the disease is diagnosed and treated by occlusion and corrective lenses, the more likely normal visual function can be obtained. The diagnosis should be made and treatment instituted by four and one-half years of age or earlier.

Problem of Visual Screening in the Preschool Child

The need for visual screening of the preschool child has been recognized for many years for the foregoing reasons. It has been approached through many avenues with small success. These children are dispersed in many groups and in many strata of our society.

Well advertised and freely offered examinations at specific times and specific places have brought forth mostly the children of interested and sophisticated parents. Examination of church and other social groups fails to reach many of the children who need visual screening examination. The endeavors of dedicated workers in the field who collect birth records with the intent of reaching the children four and one-half years later are frustrated by movements of families in and out of the community.

To this date, no thoroughly satisfactory scheme for reaching a majority of children for preschool visual screening has been found.

Role of the Physician

The most promising means of obtaining visual screening for the preschool child is an insistent and continuing plea to the physicians who care for preschool children.

Since most children are seen either a few or many times by physicians who undertake their care, it appears obvious that the burden of this service must fall upon them. Whether he sees them for routine examination, for specific diseases, for emergency care or for any other reason, he is the only possibility for their obtaining visual screening. He is direly needed in the solution of this problem. The burden falls upon him; however, it is a burden that can be made small but rewarding.

Simple Visual Examination of the Preschool Child

With an ophthalmoscope in a darkened room, a bright retinal reflex from each eye will rule out gross defects of the cornea, lens and vitreous. Cataract will be obvious.

The corneal image test for squint or strabismus can be easily carried out with a pocket penlight. The examiner should hold the penlight close to his own dominant eye, peer along it and point it at the child's eyes. The child does not have to be touched. Normally, the light reflex will fall in the center of each pupil.

Abnormally, the light reflex will fall in the center of the pupil of the fixing eye and in the nasal or temporal areas of the squinting or deviating eye. Such extracentral placement of the light reflex indicates strabismus and need for referral to the ophthalmologist without delay.

These children need to be treated as soon as the diagnosis is made, and no later than four and one-half years of age. The previously mentioned tests can be carried out in a few minutes and more rapidly with practice.

Estimation of the gross visual acuity in a child under four and one-half years of age is another matter. Even in the office of an ophthalmologist with experienced and well-trained paramedical personnel, it can be a tedious, time-consuming and often an unrewarding experience. Fortunately, the duty can be transferred to a willing parent with a few simple instructions. Several methods can be employed.

The parent is instructed to cover one eye of the child with tissue held in place by tape. With the child standing and the parent stooping, small rubber balls or marbles are rolled 20 feet or more. The child is turned loose to recover the object. Parental observation will reveal how unerringly or

erringly the child follows the object, goes to it and recovers it. Smaller marbles over greater distances can be used to refine the test. The opposite eye then should be covered and tests repeated until tenable results are obtained. The game can be repeated on successive days until the parent is assured of the testing results. Usually the mother will play the game, but if she fails and the father is the favored parent, he may obtain a more acceptable testing result.

In the child with a long attention span, again with one eye covered, a finger pointing to a plane or bird in flight across the sky can yield valuable information. The game must be repeated with the opposite eye occluded to complete the test. Birds on a telephone wire or small paper planes can be used for the same purpose.

The physician can be assured that the average parent will be grateful for his interest and instructions. They will play these games with the child willingly and will be happy to be told that the results indicate normal vision.

The parents who discover abnormal vision in one or both eyes also will be deeply appreciative of the discovery and subsequent referral. They cannot help but feel that their child is in the care of a physician who is interested in all of the child's vital functions.

Statement of the Ophthalmologist

The ophthalmological segment of the medical community is reasonably agreed on the following:

1. Every child who reveals any evidence of ophthalmic disease should be referred for ophthalmic examination.

2. It has been stated that every child should have a definitive examination by an ophthalmologist at four and one-half years of age. At that time it is usually possible to estimate the visual acuity with the Snellen illiterate E game. It is questionable whether present ophthalmic facilities are available to carry out this ideal. This should be available for children of discriminating parents.

Discussion

It is obvious that no one can replace the pediatrician and family physician in the mission of visual screening in the preschool child. With two simple tests requiring a small amount of time and a few brief instructions to parents, an adequate preschool visual screening can be accomplished. The gratitude of the parent can be obtained. More important, the welfare of the patient-child can be assured.

Summary

The need and reasons for visual examination of the preschool child is outlined and the prime role of the pediatrician and family physician in visual screening of the preschool child is indicated.

The gratitude of the ophthalmologist who receives the referral at a time when his care will produce gratifying results will be understood by every true physician.

▶ Dr. Staton, 1411 North Flagler Drive, West Palm Beach 33401.

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazone) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydrocortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Also available: Furacin® Otic (nitrafurazone with nifuraxime and diperadan HCl). The wide antibacterial range of Furacin is augmented by the antimycatic activity of Micofur® (nifuraxime). Diperadan hydrachlaride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacterial otitis externa, otamycasis or bacterial otitis media (when the eardrum is perforated).

Precautions: Sensitization to nitrafurazone may occur with prolonged use and is more likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Contraindications: The usual contraindications for preparations containing hydracortisone should be observed, such as tuberculous lesions of skin or ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrafurazone, and 1.0% hydracortisone acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrafurazone, 0.375% Micafur®, brand of nifuraxime, and 2% diperadan hydrachloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.

™Originators and Developers of The Nitrofurons
EATON LABORATORIES
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone/hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl



early relief from DEPRESSION



NORPRAMIN
(desipramine hydrochloride

At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves . . . mood fluctuations lessen . . . sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type . . . any degree of severity.

See package insert for complete prescribing information

LAKESIDE

improvement often begins in 2 to 5 da

IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects ve been encountered: dry mouth, constipation, d ness, palpitation, delayed urination, agitation d stimulation ("jumpiness," "nervousness," "anxi "insomnia"), bad taste, sensory illusion, tinn sweating, drowsiness, headache, hypoten n (orthostatic), flushing, nausea, cramps, weak s blurred vision and mydriasis, rash, tremor, al g (general), altered liver function, ataxia and e a- pyramidal signs, agranulocytosis.

Additional side effects more recently repo d include: seizures, eosinophilia, confusional st e with hallucinations, purpura, photosensitivity, g c- torrhea, gynecomastia, and impotence. Side ef ts which could occur (analogy to related drugs in- clude weight gain, heartburn, anorexia, and n and arm paresthesias.

DOSAGE: Optimal results are obtained at a do g- of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hy o chloride) tablets of 25 mg.; bottles of 50, 500 nd 1,000; and tablets of 50 mg. in bottles of 30, 0, and 1,000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 5 01



choose an experienced candidate—
millions of doses prescribed

Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma. seasonal allergies. sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



From the Editor

Franz Stewart

Politics
Like any road
Is just for riding.
Votes are arrows sped.

Belleair Florida

"The health of the people of any state does not depend solely on the type of medical care available. Other factors exert profound influences, chief among them being education, environment, housing and nutrition. . . .

". . . We have failed to take cognizance of the need for constant postgraduate instruction and training of the Negro physicians. Though we expect these men by some untold miracle to give proper medical care to their share of the Negro population, we deny them scientific education and training which we could easily and efficiently give.

"The health standard of a community is not judged by the standard of the white citizens but by the standard of all citizens. Of what has America and American Medicine to be proud if one half or three fourths of the population has the highest standard of health in the world while the other half or one fourth has the lowest? It is time for organized medicine in Florida to face these fundamental facts with scientific and logical realism. I aver that it is the duty of the Florida Medical Association and of each member of the Association, to make available to the Negro doctors every possible advantage in scientific medical education and training. This duty is not to the Negro doctors alone, nor to the Negro population alone; it far transcends in importance any limitation to any one group of people since health and medical care are of fundamental importance to every individual in the state. . . ."

FMA Annual Meeting April 1949
Joseph S. Stewart, M.D.

The choice of type, graceful and effective setup, skilled and artistic printing, all added to good workaday procedures are the framework upon which any excellence of magazine communication depends. With us the word *format* might well be changed to the word *Solomon* or would *Convention Press* be better?

In autocracy
It's submit or revolt.
In democracy
It's submit or vote.

CONVENTION PRESS

2111 NORTH LIBERTY ST.
JACKSONVILLE, FLORIDA
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL
AND DENTAL
PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT since 1932 PM FOR PHYSICIANS AND DENTISTS

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

Rx ROERIG

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

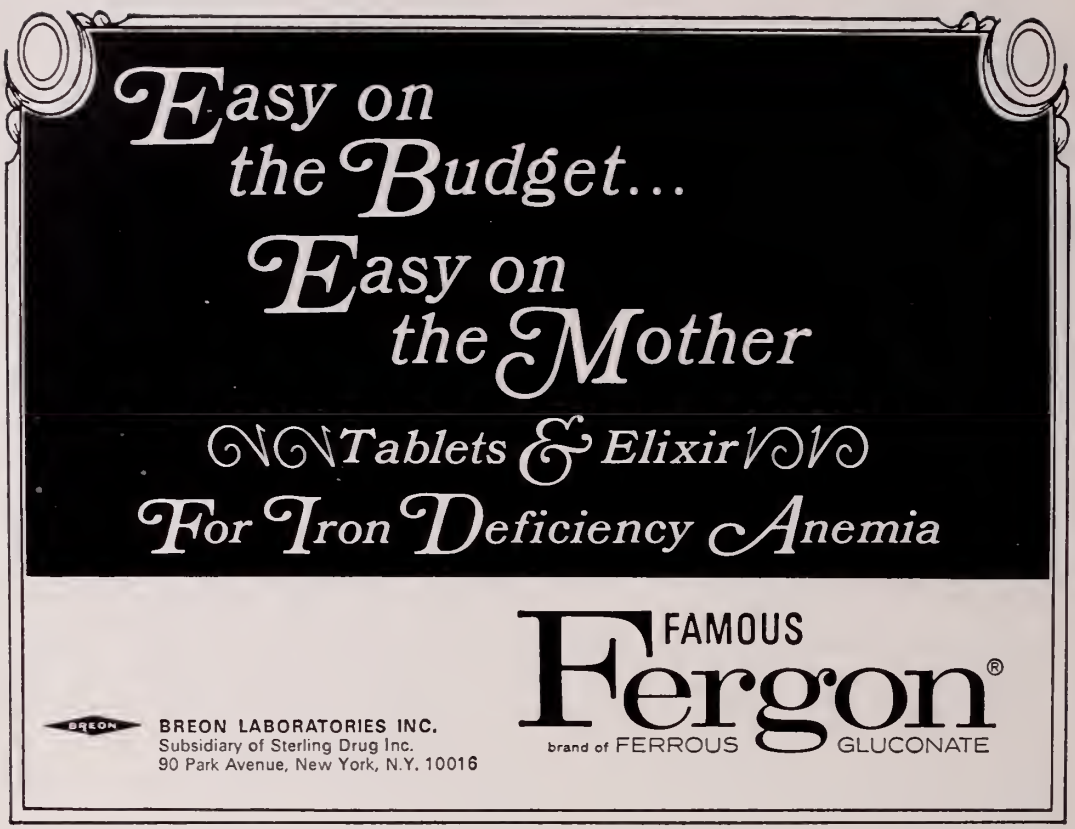
TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017



TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

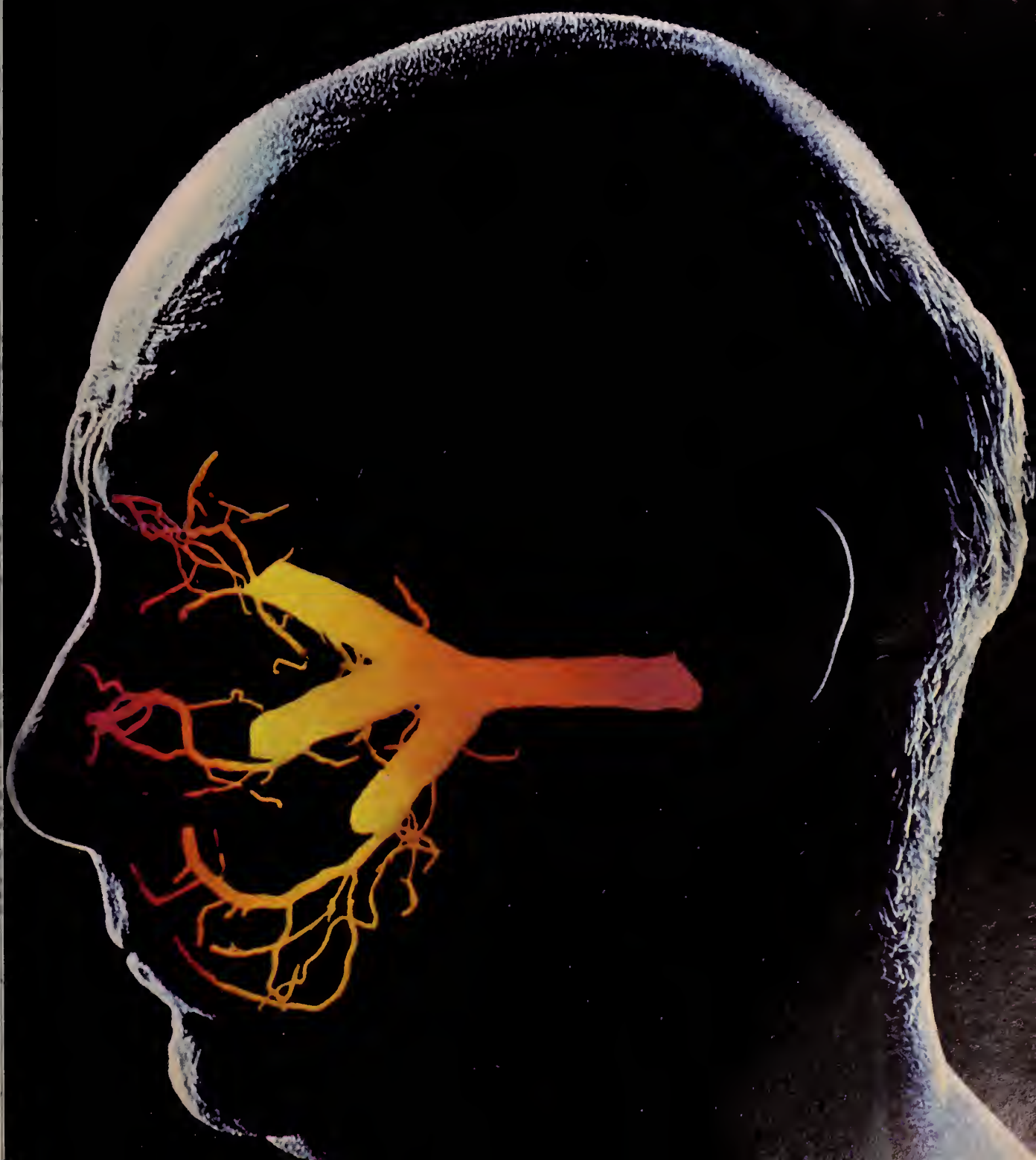
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dr should be discontinued.
2. Liver function tests must be performed at regular intervals during tr ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tono etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities i liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri impotence, disturbances of coordination, confusion, headache, fatigue blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryth multiforme and nodosum, aggravation of disseminated lupus erythema tosus, gastric distress, abdominal pain, diarrhea, constipation, anorex dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypo tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular ef are drug-related is not known. However, some of these complications resulted in fatalities.) The necessity for discontinuing the drug should dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with mea if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the d should be increased in one-half tablet (100 mg.) increments every 12 h until freedom from pain is achieved. To relieve pain, between 200 mg. 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geig

uncommon relief of uncommon pain



The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."



TO-5757

..Forlorn"

"Had a divorce."
"I'm a real loser, and so are the kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of

LOMA LINDA FOODS

MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U.S.A.



Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 01BR67



Florida Medical | comment

The Nurse and Physician
Associates in Patient Care and Communication

Samuel R. Warson, M.D.

At a joint meeting of representatives of the Florida Medical Association and the Florida Nurses Association in Orlando June 7 and 8, 1968, the relationship of these two professions was discussed in general and in small group sessions. This was the first organized effort to bring these two associations together on a statewide basis in Florida and reflects a general movement initiated by our national organizations to promote grass roots interdisciplinary action with the goal of improving relationships between the professions for the better care of the patient.

The immediate barrier to good working relationship became quickly apparent and was recognized by the participants as a problem in communication. Time did not permit a "working through" of this problem and it was anticipated that the process would continue at a local level. Although no guidelines were given it was obvious that the ultimate goal could not be reached until the problem of communication was worked through, and in this connection the experience of psychiatrists could be of some assistance.

Problems of communication have been a concern of psychiatry since the beginning of its interest in psychodynamics, and the development of a working approach to such problems within the framework of medicine has been a major contribution of psychiatry to the understanding and use of the patient-physician relationship in medical practice. This contribution has been handed on to other health-related professions because of its applicability to problems of communication in general.

Very simply, from an operational point of view the psychiatric approach to communication stresses *listening* rather than talking, and *involvement* rather than the taking of positions. These are not simple processes; however, they demand a great deal of knowledge and experience, which to some extent can be acquired through education but also is based on what Hippocrates called "the art" or the use of creativity.

Listening

Listening goes far beyond simply allowing the patient to ask questions to which answers can be given. Frequently it is more important to listen for what is behind the question, something which may be expressed non-verbally or at a feeling level, because the question may not be a request for information but a message expressing feelings that we can pick up through our own feelings. So we "listen" with our ears, our eyes and our own feelings. For example, we may feel hostility behind what appears to be a simple question, such as why do doctors do this or that, and if we are not alert to the validity of our feelings as medical observers, we may react personally and lose the opportunity of finding out what is disturbing the patient.

Involvement

Involvement does not mean taking over the problems of patients in a sympathetic manner,

Dr. Warson is professor of psychiatry, University of Florida College of Medicine, Gainesville.



After the picnic
even Gramps
Was a victim of
intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

ROER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

but rather it means empathizing with their experiences to the end of helping them to deal with feelings that are influencing or complicating the medical situation. We never can experience the pain and discomfort of our patients, but through involvement we can appreciate what they are experiencing and diminish their sense of isolation and their reactions to it. The degree and nature of the involvement will vary from patient to patient because of its creative aspect as well as circumstances, but some degree of involvement is necessary for good communication.

A Change in the Medical Model

Historically, the development of this approach to communication has been paralleled by a change in the medical model and in the relationships between other health-related professions and medicine, particularly psychiatry. When psychiatry was primarily concerned with diseases as such, it had all of the problems resulting from a lack of communication with other health-related professions that were expressed at the meeting in Orlando. As psychiatry shifted its concern from the disease to the patient, however, it developed a different orientation toward illness and an awareness of its medical role in practice as that of going beyond the technical or scientific aspects of medicine. This change was reflected in a change in psychiatry's relationship to the nurse; we found a new use for the nurse, not as an assistant but as an associate in our work with patients. We learned to trust the observations of the nurse about the behavior of the patient, particularly feelings that might not be expressed to the physician. We also made the nurse a responsible member of the team in the use of such observations in the treatment of the patient.

As a result, psychiatry has done relatively well in the competition for nurses. Our complaint now is not that nurses do not do what we tell them to do, but that many nurses have not defined very clearly their areas of competence beyond this role and acted accordingly. Perhaps they, like some physicians, are under the handicap of the traditional role of the nurse, a role in which she faithfully carries out the orders of the physician in a scientific manner, but does little else. Even Florence Nightingale went beyond this.

Certainly both medicine and nursing are bound to the scientific method, but they are not bound to science as a substitute for human relationships. These relationships have become better under-

stood through the use of the scientific method, but in practice such knowledge is subservient to the art of creating a relationship through which our scientific knowledge can effectively be used.

Before a meaningful dialogue can be established between physicians and nurses there must be some awareness of changes in the medical model and in the roles of physician and nurse in the delivery of medical services. This awareness will be accelerated by following the principles of listening and involvement which have served so well in the improvement of patient-physician relationships. The catalyst is mutual respect for the competence of professionals, which means that physicians will have to give more than lip service to the concept of nursing as a profession and that nurses will have to clarify their areas of professional competence beyond carrying out the physician's orders.

Both the nurse and the physician should appreciate that changes in the models of medicine and nursing require a change in our concepts of the relationship between these professions—a change that can take place through dialogue, as the philosophers long ago learned.

Renaissance in Jacksonville

This birthday celebration of a significant date of progress in Jacksonville seems of such interest to all of us that we asked Gene Nixon to tell us about it.—Ed.

A new era began October 1 in the city of the Florida Medical Association's birth. This date marked the official beginning of the Jacksonville-Duval County consolidated government. It was specified in the city's new charter which was approved during the 1967 session of the state legislature, after having been overwhelmingly endorsed at the polls by the area's citizens. The occasion was celebrated throughout the day by parades, fireworks displays and ceremonies.

Under consolidation, the former city of Jacksonville and county of Duval now function under a single government, guided by an elected mayor and legislative council. The only exceptions in Duval County are four outlying suburban communities which chose to retain their separate identities. According to civic leaders, Jacksonville is now the state's largest municipal entity in population and the nation's largest in land area. The massive change in government, which was several years in the making, is considered by many to be the most significant step forward ever made by the St. Johns River community once known as Cow Ford.



The Bettman Archive

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg; Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

A new Division of Health and Welfare now supplants the former city and county health departments and county welfare department.

Paralleling the governmental changes is an accelerated expansion of practically all area hospital facilities. Duval Medical Center, the county hospital in which many Florida physicians spent their internship and residency training, is constructing a new 500-bed general hospital adjacent to the old facility, which is planned for conversion to intermediate care use. Riverside Hospital recently opened an all new 159-bed plant. Work is underway on additions to Baptist Memorial Hospital that will increase its capacity by some 200 beds by 1971 or 1972. St. Vincent's Hospital is undergoing an $8 to $9 million program primarily to improve and expand its outpatient, diagnostic and ancillary facilities. St. Luke's Hospital, the city's oldest, is building new intensive and chronic care units which will result in a net increase of 86 beds. Methodist (formerly Brewster) Hospital recently reopened with a capacity of 166 beds following a complete reorganization and renovation. Also extensively renovated was Hope Haven Children's Hospital.



New Duval Medical Center

The new Memorial Hospital in Jacksonville's Southside area is scheduled for completion early in 1969. Its initial number of beds will be 200. The Beaches Hospital at Jacksonville Beach recently opened a 50 bed addition. Within the past year a new 400-bed general hospital was dedicated at Jacksonville Naval Air Station.

If Dr. Abel S. Baldwin—the Jacksonville physician who called key state doctors together in his office to form the Florida Medical Association in 1874—were to return today, it is doubtful he would recognize his home city. Recalling his civic interest and spirit, however, it is certain he would be in the forefront of the renaissance of Florida's "Bold New City of the South."

Our Mail

Subtlety

That you could put words together and make them flow like a rippling brook, no one would doubt or even question. Many of us for years have admired your deftness and finesse in the use of the spoken or written word.

As if to lend credence to this opinion, along come your comments on "History" in the August issue of the JOURNAL. Ah, what magnificence of rhetoric, what mastery of the use of words, what subtlety of meaning! In fact, so subtle that I must confess shamefacedly that some of the meaning escaped me. My impulse was to make like I had never read it so as to wipe out that terrible feeling of self-inadequacy or uncleverness.

My predicament brought to mind an appropriate piece of Biblical prose which I had seen recently scribbled across, of all places, the wall of a men's room, to wit:

> And it came to pass that the Barbarians from the North
> Came upon the wall and its writings;
> And knowing not what it meant
> They destroyed and defaced it so that
> Others would not know what
> They did not.

I know not the author, but I do know how the Barbarians must have felt.

FRANKLIN J. EVANS, M.D.
CORAL GABLES

Governor's Comment

Dear Governor Kirk:

We are taking the liberty of mailing to you the June issue of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION. This journal long has been a part of Florida, representing as it does a mirror of Florida medicine. With the June issue the JOURNAL is trying even more to picture doctors and their related activities as one facet in the overall life of the state.

As new editor of the JOURNAL, I thought one of the first things that should be done is to send the governor of our state a copy. I hope you will do us the honor of looking this over and that you will approve of our efforts to emphasize the

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R-6064

importance to each of us of the state as a whole, a place, a responsibility and a part of our lives. .

Franz H. Stewart, M.D.

Dear Dr. Stewart:

Thank you so much for forwarding the copy of the June issue of the Journal of the Florida Medical Association.

The current emphasis on health throughout the country, particularly in Florida, places the medical profession and your association in the forefront for serving the public interest. I wish you every success. . . .

Claude R. Kirk Jr.

Memoirs

You have done a grand job with mother's memoirs — congratulations. I'm thoroughly pleased. Also I have read the August issue of the Journal from cover to cover. The article on early medicine in St. Augustine I found most interesting but the one I especially enjoyed was on Dr. Howell Tyson Lykes. My college roommate was D. B. McKay's daughter, Helen. The next to Helen was named Margaret Almeria after her. I think that she, Mrs. Lykes, was their aunt. A McKay cousin, Gavino Colado, was a captain on one of the Lykes freighters and the whole McKay family (ten children) went back and forth to Spain on the ship quite regularly. Incidentally, Mrs. D. B. McKay's father was the first Spanish consul in Tampa and brought Mr. Ybor to this country—Mrs. McKay was a Guiterrez. You see why I am always interested in Florida history. Thank you again.

Dorothy Darrow
Coral Gables

Honored

Being the artist who illustrated Dr. Straight's article in the August 1968 issue of the Journal of the Florida Medical Association, I also am very proud of the fact that you chose one of the illustrations for your cover subject, for which I thank you.

I also wish to extend to those responsible for the unique and artistic format congratulations for a job extremely well done.

Newton Randum
Miami

Congratulations

Congratulations on the history section included in your August Journal. The articles will be of great interest to the general public and the history buffs, as well as medical persons.

I have forwarded my copy to the publisher of Florida Trend magazine, Mr. Harris Mullen. The article by Dr. James Ingram on Dr. H. Tyson Lykes should get some distribution by the Tampa Chamber of Commerce and the Port Authority.

Charles S. Thomas, Director
Community Relations
St. Joseph's Hospital
Tampa

Improvement

I should like to tell you how much I think the Florida Medical Association Journal has improved not only in content but also in its appearance. Every month the cover brings a new surprise and aesthetic pleasure.

Congratulations.

Emanuel Suter, M.D., Dean
University of Florida
College of Medicine
Gainesville

Appreciation

A resolution, proposed by Dr. James J. DeVito, has been unanimously passed that a letter of appreciation be sent to you for the excellent articles on medicine in Florida that appeared in the August issue of the Journal.

Our society appreciated particularly the interesting article by Dr. William M. Straight on "Medicine in St. Augustine During the Spanish Period."

Vernon A. Lockwood, M.D., Secretary
St. Johns County Medical Society
St. Augustine

Superb

This note is to tell you how pleased I am with the August issue of the Journal. It is superb—I am quite proud of it. The art work and format adds greatly to its interest. Thanks for your efforts and those of your staff.

William M. Straight, M.D.
Miami

Wilbur Cohen

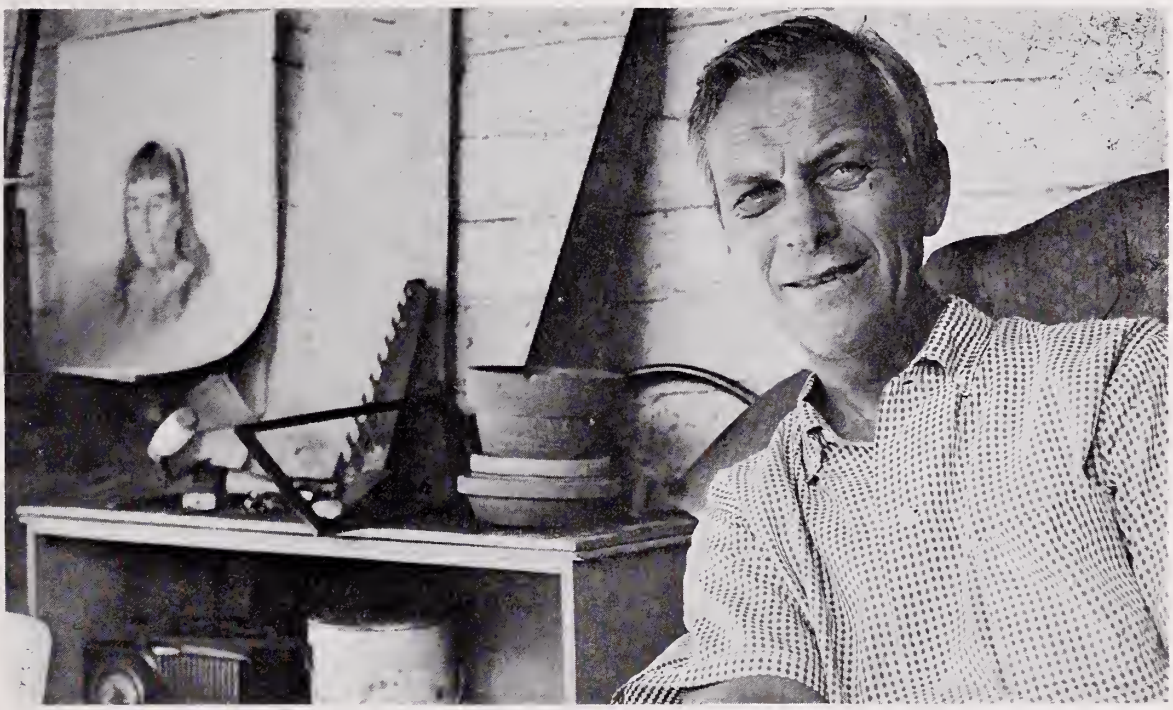
The July proceedings issue of the JOURNAL, *pages 640-642, described this matter. Note that the resolution was killed in reference committee at the AMA meeting in June—Ed.*

At the May meeting of the FMA I took to the floor a resolution decrying the appointment (whether postfacto or not) of one Wilbur A. Cohen to the position of Secretary of Health, Education, and Welfare. This passed the House of Delegates nicely and was to the best of my intention given a fair trial at the AMA. I was not in attendance at the House of Delegates meeting when it was presented, but I did take part in the heated and lengthy discussion at the reference committee meeting.

The real purpose of this comment is to decry the fact that there is no mention of this resolution, its discussion, or its fate in the Briefs issued by the Florida Medical Association following its annual meeting. I am sure this was an oversight, but because of the opposition of some of the higher members of the echelon I do wonder if there was not some approval of such an oversight. I would hope that . . . by publication of this letter . . . the Florida Medical Association membership (will realize) that the House of Delegates actually went on record on an overwhelming voice vote to decry the appointment of Wilbur Cohen.

This decision of the House of Delegates was in keeping with the tenet I have fully believed in for many years, "Because something wrong has been accomplished, this does not make it right."

WALTER W. SACKETT JR., M.D.
MIAMI



Kenneth DeGarmo, who did our cover this month, is a native of Coconut Grove. He attended both the Pennsylvania Academy of Fine Arts and the Cape Cod School of Art. He drew sports cartoons for the Miami Herald and was editorial art director of the old Miami Daily News. A member of the background department of Fleischer Studios, he did many of the scenes for "Gulliver's Travels," "Popeye" shorts, "Mr. Bug Goes to Town" and "Hunky and Spunky." Murals and portraits were part of his Navy life during World War II; later came architectural rendering and design. Mr. DeGarmo currently is technical illustrator for the Dade County Park and Recreation Department at Villa Vizcaya.



Geigy



Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.



One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B) 46-600-C

For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RC-6225

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

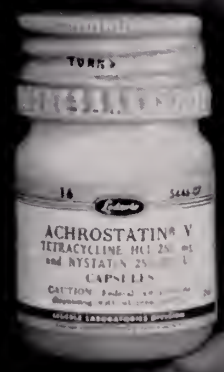
each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French, Laboratories

From the First Family of Tetracycline– One of the 31 useful dosage forms in the ACHRO Family

ACHROSTATIN® V Capsules

Tetracycline HCl 250 mg /Nystatin 250,000 units



The lowest priced tetracycline-nystatin combination

Lederle

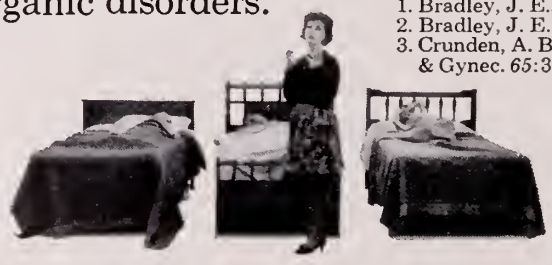
329-B/6094



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

Florida Medical | feature

The Admiral's Physicians

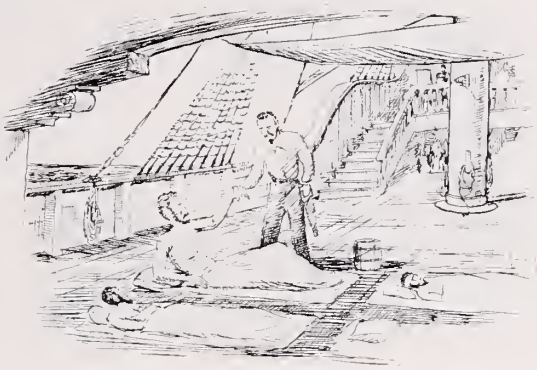
William M. Straight, M.D.

Life aboard the ships of Columbus was hard by modern standards. The living accommodations were not very different from those to be seen on the Charles W. Morgan, the old whaler at Mystic Seaport. Although Columbus and possibly his first officer had a cabin with a door on it, his crew and both the officers and crew of the other two vessels had to sleep and eat under the unenclosed overhang of the quarter deck. In exceptionally foul weather the crew could go below the main deck into the cargo hold, but ventilation of this compartment was by way of the hatch and this would have been closed in bad weather. The bedding was probably mats spread on the deck. On the return trip possibly some of the crew used hammocks, a trick they learned from the natives of Hispaniola.

Food at sea was largely hardtack (very likely infested with weevils), salt beef, pork or fish, cheese and quantities of olive oil, which helped to make it all palatable. Casks of wine and water supplied the liquids. Columbus probably carried much more wine than water, for wine kept better and was more acceptable. After a few days or weeks at sea, the water, infested with algae, became cloudy and gave off a foul odor.

The sanitary facilities were seats rigged outboard of the forerail and there hung a rope's end for cleanliness. Despite these Spartan accommodations and limited food supply, health at sea seems to have been no problem on the first voyage.

When "The Admiral of the Ocean Sea" embarked from Palos, Spain, on Aug. 3, 1492, he carried with him a surgeon or physician aboard each ship. Aboard his flag ship, the *Santa Maria*, was Master Juan Sanchez to care for the crew of 39. Sanchez is referred to as a *cirujano* suggesting that he was a guild surgeon and not merely a barber surgeon. He was a member of a prominent



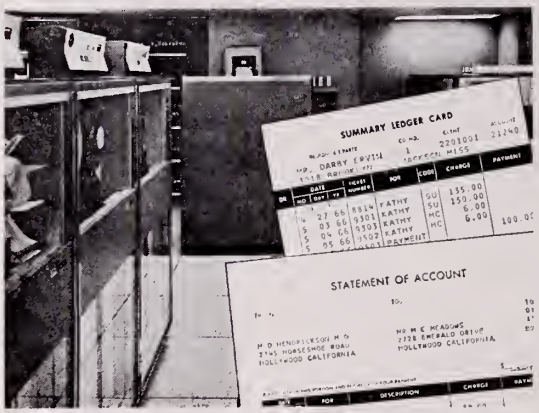
Aboard ship

family of Cordoba who were long-time friends of Columbus. Aboard the *Pinta* was Master Diego, probably a barber surgeon, to care for its crew of 26. And aboard the *Nina* with a crew of 22 was Master Alonzo, who is referred to as *fisico,* suggesting that he was a university trained physician, though possibly not to the extent of obtaining a degree. Two of the physicians, Master Sanchez and Master Alonzo, volunteered to stay behind with the group of 40 in the colony of La Navidad which Columbus founded near Cape Haitian where his flagship ran aground and was lost.

On his second voyage Columbus, commanding 17 ships and about 1,200 men, set sail from Cadiz on Sept. 25, 1493, and reached the West Indies in 21 days. Aboard his flagship, again called the *Santa Maria,* Columbus carried as physician to the fleet an extraordinary man, Dr. Diego Alvarez Chanca. Dr. Chanca, the first graduate physician to see the New World, was paid from the Royal treasury the salary and rations of a scrivener. Apparently the doctor had been a very prominent physician in Seville and made it known to Columbus that he had made a much greater income in practice than he was receiving on the voyage.

AUTOMATED MANAGEMENT SYSTEMS OF FLORIDA, INC.
FIRST FEDERAL BUILDING
8340 N.E. 2ND AVENUE
MIAMI, FLORIDA 33138

Accounts receivable management system designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable maangement with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are a National Concern serving Doctors for over seven years.

☐ Please send me your Accounts Receivable Management Brochure.

☐ Please have one of your consultants call me for an appointment.

Name

Addresss

City Phone

Thereupon, in consideration for his "greatest zeal and kindness in everything that relates to his profession," Columbus awarded him 50,000 maravedis in addition to his salary as a scrivener.

It is difficult to convert this to current dollars but an idea of the value of this amount can be obtained by the cost of certain items noted in the documents of Menendez (c 1580) and quoted by Arnade. One barrel of wine cost 2,431 maravedis, a coat of mail 18,700 maravedis, three quarter barrels of salt beef 374 maravedis and a guitar 187 maravedis.

The best account of Columbus' second voyage is the letter written by Dr. Chanca to the Chapter of Seville. Although the letter sets forth many details of the voyage, we will limit our attention to notations of medical interest. The first of these letters recounts how some of the crew who landed on the island of Marigalante "not very prudently" tasted fruits (possibly manchineal) "and upon only touching them with their tongues, their countenances became inflammed and such great heat and pain followed, that they seemed to be mad, and were obliged to resort to refrigerants to cure themselves."

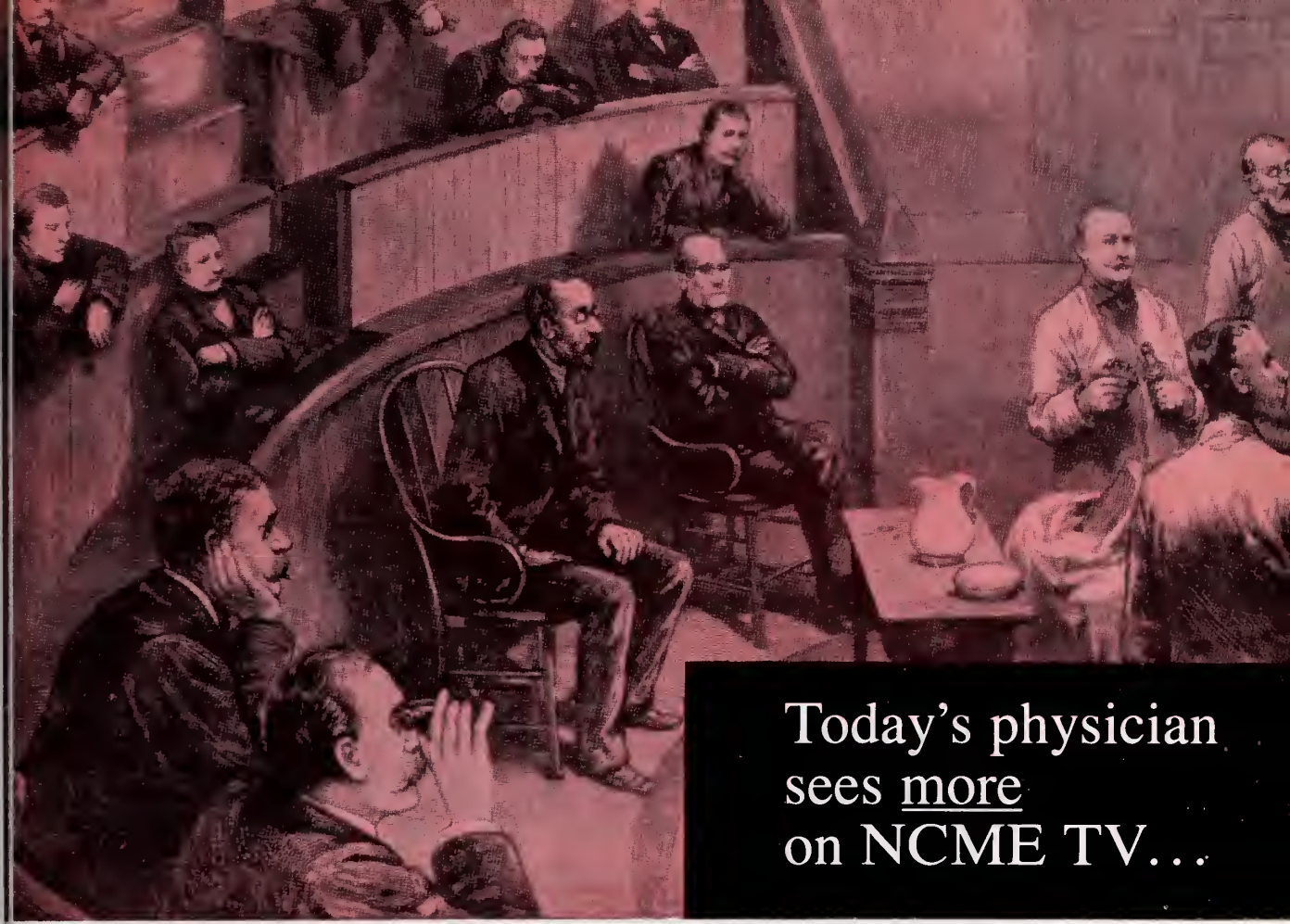
Dr. Chanca tells of the Admiral's return to La Navidad to find it "burnt and leveled with the ground" and its inhabitants missing. Later,



Columbus returns

the doctor himself went ashore and inspected "the bodies of eleven of the dead Spaniards . . . which were already covered with the grass that had grown over them." He estimated their death "not two months before our arrival." Thus, Dr. Chanca became the first European to serve as a coroner in the New World. Although the evidence was equivocal, Dr. Chanca thought it likely that the Indians had murdered the Spaniards in revenge for plundering and rape carried out by undisciplined members of the colony. Among the dead were Master Sanchez and Master Alonzo, the surgeon and physician of the first voyage.

Dr. Chanca also uncovered the deceit of the



Today's physician sees more on NCME TV...

MANN ARCHIVE

he first nationwide medical evision service, NCME—The twork for Continuing Medical lucation—brings you visually the portant achievements of leading dical authorities. By means of osed-circuit television, this indendent network provides your spital or medical school with a mplete videotape service that lps shorten the gap between new dical knowledge and its availabil- for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medieal subjects is sent to participating institutions.

☐ Content and format of NCME teleeasts fulfill eriteria for postgraduate medical education, permitting American Aeademy of General Practice eourse ereditsunder speeified conditions.

☐ To help your institution make effeetive use of closed-eireuit television, NCME offers a wide range of serviees and utilization aids, including: Technieal consultation in setting up a closed-circuit system; advance program information on the contents of each teleeast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you ean view the teleeasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-eireuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vaseular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliae, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be eompleted faster, eauses less damage to the arteries and offers a more successful outeome.

NCME is an indepeudent network supported by Roche Laboratories to inerease the use of closed-eircuit TV for medical edueation under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

local caique, Guacamari, who feigned a wounded thigh sustained in defending the colonists of La Navidad against the hostile Caonabo and Mayreni Indians, whom Gaucamari alleged had destroyed the colony. Columbus visited Guacamari at his village when the latter claimed he was unable to come to the Admiral. Columbus insisted that Chanca and a surgeon treat Guacamari's wound. After the surgeon had unwrapped the thigh, Chanca inspected it and reports, "It is certain that there was no more wound on that leg than on the other, although he cunningly pretended that it pained him much."



"I see no wounds."

Dr. Chanca has left us vivid descriptions of the new land, the plants and animals and the natives and their customs. He tells us, "They all, as I have said, go naked as they were born except the women of this island [Hispaniola, now Haiti-Dominican Republic], who some of them wear a covering of cotton, which they bind around their hips, while others use grass and leaves of trees. When they wish to appear full dressed, both men and women paint themselves, some black, others white and various colors, in so many devices that the effect is very laughable: they shave some parts of their heads, and in others wear long tufts of matted hair, which have an indescribably ridiculous appearance: in short, whatever would be looked upon in our country as characteristic of a mad man, is here regarded by the highest of the Indians as a mark of distinction.

"Their food consists of bread made of the roots of a vegetable which is between a tree and a vegetable, and the *age*, which I have already described as being like the turnip, and very good food; they use, to season it, a spice called *agi*, which they also eat with fish and such birds as they can catch of the many kinds which abound in the island. They have, besides, a kind of grain like hazel-nuts, very good to eat. They eat all the snakes, and lizards, and spiders, and worms that they find upon the ground; so that, to my fancy, their beastiality is greater than that of any beast upon the face of the earth."

Of the warlike Carib Indians, Dr. Chanca states, "In their attacks upon the neighboring islands, these people capture as many of the women as they can, especially those who are young and beautiful, and keep them as concubines; . . . These women also say that the Caribbees use them with such cruelity as would scarcely be believed; and that they eat the children which they bear to them, and only bring up those which they have by their native wives. Such of their male enemies as they can take alive, they bring to their houses to make feast of them, and those who are killed they devour at once. They say that man's flesh is so good, that there is nothing like it in the world; . . . When they take any boys prisoners, they dismember them, and make use of them until they grow up to manhood, and then when they wish to make a feast they kill and eat them, for they say that the flesh of boys and women is not good to eat. Three of these boys came fleeing to us thus multilated."

Dr. Chanca appears once more on the stage of history. In 1494, Columbus, exploring off the coast of Cuba, developed a high fever with alternate delirium and coma. He was taken to Isabella, the colony on Hispaniola he had founded during his second voyage, and was nursed back to health by his friend, Dr. Diego Alvareza Chanca.

Thus, of the first four physicians to come to the New World, two were massacred in the ill fated colony, La Navidad, one returned to Spain and is lost to history and the fourth remained in Columbus' second colony to become its physician and historian.

References

1. Roddis, Louis H.: The First European Medical Men in the New World, Military Medicine, 129:1031-1035, (Nov.) 1964.
2. Editorial: Compass and Caduceus, MD Magazine, 137-141 (Oct.) 1958.
3. Chanca, Diego Alvarez: A Letter Addressed to the Chapter of Seville by Dr. Chanca, native of that city, and physician to the fleet of Columbus, in his second voyage to the West Indies, describing the principle events which occurred during that voyage, Select Letters of Christopher Columbus with Other Original Documents, Relating to His Four Voyages to the New World, edited by R. H. Major, London, The Hakluyt Society, 1870, p. 19-107.
4. Arnade, Charles W.: Florida on Trial, 1593-1602, University of Miami Hispanic American Studies, No. 16, Coral Gables, Fla., University of Miami Press, p. v.
5. Roddis, Louis H.: A Short History of Nautical Medicine, New York, Paul B. Hoeber, Inc., 1941.
6. Landstrom, Bjorn: The Ship, Garden City, New York, 1961.

▶ Dr. Straight, 550 Brickell Avenue, Miami 33131.



When she gets a bacterial infection, think of Tetrex-F.®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

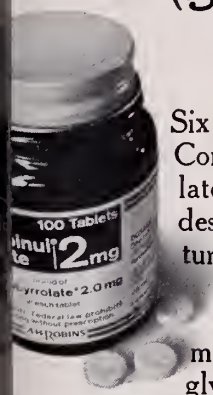
Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

In peptic ulcer therapy, won't you ive Robinul® Forte a Fair Trial?

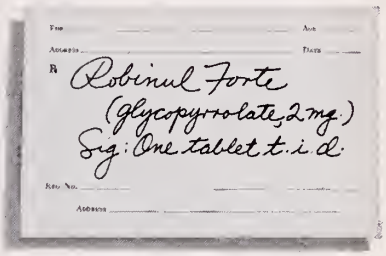
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) nd good acceptance among numerous physicians, y others just didn't seem to want to give it a try, ably because the anticholinergic they were aly using was giving acceptable results.

wever, we believe you'll agree there's always n for a better anticholinergic. This is why we're ng you to give Robinul Forte a fair trial. Robinul e exerts a highly specific antisecretory action and ked inhibitory effect on intestinal tone. We're con- ed you'll agree that this is indeed an outstanding when you observe its outstanding suppression of r symptoms. Furthermore, it is unique in that it ces intestinal tone, yet has little or no effect on talsis. In addition, the incidence of the more ersome peripheral side effects is low.

longer does the physician have to look for extreme mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.



"COCA-COLA AND COKE ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

Captain of the Ship in O.R.

Ben J. Sheppard, M.D., LL.B.

In Florida, the idea that the surgeon in an operating room was the "Captain of the Ship" was a fairly accepted fact. A recent decision by Florida Appelate Court, however, has altered the course a little.

As background, two different persons may at the same time severally stand in the attitude of master in some respect of the same agent with reference to different aids he may have to perform. One may be his principal as to one act or class of aid and the other his principal as to another aid. The borrowed servant doctrine, then, simply means that an employer in the general employ of one employer may, with his consent, be loaned to another employer and become servant or employee of the one to whom he has been loaned, provided the borrowing employer has "exclusive" control over the employee's work.

At the time of the sponge count, traditionally, the finger points to the surgeon as "Captain of the Ship." The jurisprudential frame of mind then came to the conclusion that where we have a patient with a retained sponge in his belly, the pleadings squarely presented the question of whether or not the nurse was the agent of the hospital or the surgeon. In Wilson v. Lee, Memorial Hosp. 65 So. 2nd 40, it was decided that this is a jury question. Several other decisions have repeated this and the question of who was the liable principal of the retained sponge became a jury question.

Now, Judge Charles Carroll, Fla. App. Ct. 3rd District, in entering the decision in Bazan v. Mercy Hospital, Inc., Oct. 10, 1967, faced the question clearly and stated that at the time of the sponge count the nurse was servant of her principal, the hospital. The court stated that some duties of a nurse in the operating room are administrative or ministerial, or nonprofessional, while other duties are professional or tend towards skilled aids. Justice Carroll stated that the nurse, while performing those duties which are skillful, becomes the borrowed servant of the doctor under his exclusive control.

The appellate court stated that sponge counting is an act which could have been done by an unskilled on untrained employee and it did not involve the exercise of professional judgment.

If not performing the skilled nursing act, then the nurse is performing the administrative act and when so occupied with administrative duties becomes the servant of the hospital as a matter of law under the doctrine of "Respondent Superior."

We are faced, then, with the question of "What was done?" Was it professional, that is, skilled or was it administrative? "This case resolves the question," Judge Carroll went on to say. The nurse therefore remains the employee of the hospital for the purpose of the sponge count and negligence in performing the activity connected with it will create liability for the hospital.

▶ Dr. Sheppard, 266 Palermo Avenue, Coral Gables 33134.

On Playing Odds

Donald L. Howie, M.D.

Coincidence of deaths sometimes may raise suspicion where an isolated death may not. Often these suspicions prove unfounded.

One morning we were called to investigate the death of a woman who had been found dead in bed. The scene included a two bedroom house with the woman not only dead but showing early rigor mortis. She was in her forties. The elderly gentleman with whom she lived put forth the distinct impression that this woman was his niece, but appeared purposely vague on the details. We never confirmed the relationship. The woman previously had been known to police as an alcoholic and apparently had lived in several households over the past few years. In one bottle there were some Demerol tablets which had been obtained illegally through a pharmacist who since had left the community. Other medications included large quantities of aspirin preparations. On the floor was an open aspirin bottle and aspirin tablets were scattered in the bed. This initially gave the impression of being a salicylate suicide.

The blood level of salicylate content was not unduly elevated, however, and was certainly far below suicidal levels. An autopsy was performed and easily explained her search for pain killers. The woman died of a ruptured berry aneurysm of the middle cerebral artery. Adequate evidence of previous bleeding existed. We assumed she had headaches.

Three weeks later a call was received from the same household indicating that the old man had died. The circumstances sounded quite usual, although we had little history. The man had gone fishing the morning before death and apparently had died in bed that night. No evidence of ingestion of excess medication existed and the natural assumption was made that the death was caused by arteriosclerotic heart disease.

Results of the autopsy disclosed advanced coronary arteriosclerosis, signs of a past myocardial infarct and evidence of fresher myocardial damage. There was no indication of injury or of overdose of medication. This death, too, appeared quite natural.

In both of these instances we had inadequate history as to the cause of death, a social history that suggested the possibility of abnormal deaths and, at least in the second instance, a peculiar coincidence.

As medical examiners we have a choice of doing a postmortem examination or of signing a death certificate on the basis of probable history. When we meet circumstances which are unusual we feel justified, perhaps even compelled, to conduct a complete investigation. The medical examiner must be an instrument for the proper gathering of information bearing on the decision as to whether crime is involved. Any medical examiner law must allow for reasonable but complete exercise of judgement in this area.

▶ Dr. Howie, Mound Park Hospital, St. Petersburg 33731.

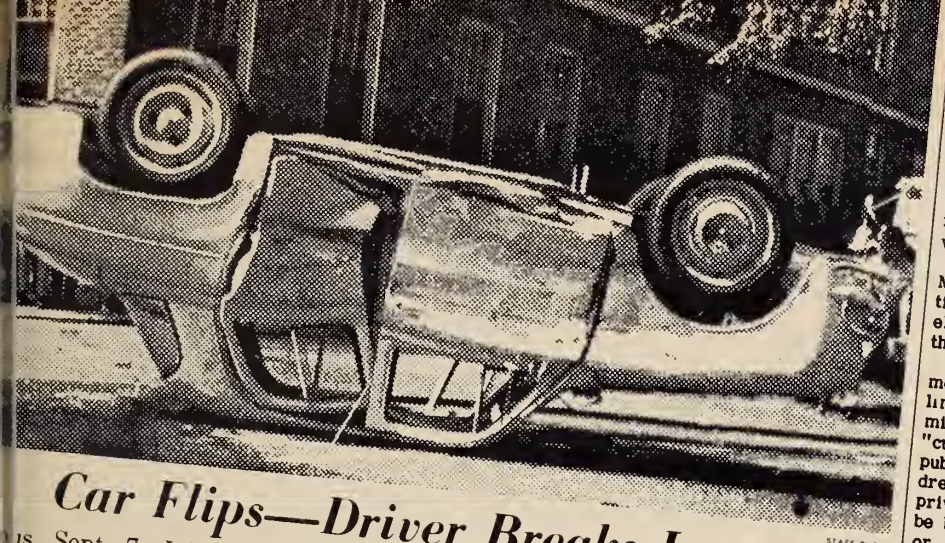
Dating International Certificates of Vaccination

The World Health Organization (WHO) has recently called attention to the requirement in the "International Sanitary Regulations" (ISR) that all dates [on certificates of vaccination] should be recorded in the following sequence:

Day	Month	Year
2	May	1968

WHO points out that difficulties continue to arise because of the use of arabic figures for recording the month. In the United States and some other countries, it is the custom to write the month (either in letters or arabic numerals) before the day. It is common practice in most countries, however, to follow the ISR format. Thus, an American physician who vaccinated one of his patients on Nov. 2, 1965 may have written the date as "11 2 65." A quarantine inspector in Europe would assume that such a certificate was issued on Feb. 11, 1965. He would, therefore, consider the certificate invalid because of apparent issuance more than three years prior to the present time. No misinterpretation is possible, however, if the date were indicated as prescribed by WHO, that is, "2 Nov. 65." □

Reprinted from Morbidity and Mortality Weekly Report, June 8, 1968, p. 213 as reported by Foreign Quarantine Program, NCDC.



STAFF PHOTO

Car Flips—Driver Breaks Leg

...is, Sept. 7. John P. Jones of ... incurred a broken leg today ... driving ...

Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its ... Hasn't he ... ...itar

For se... board h... statemer... issue, a... tember th... fications'... ton dicta...

Althou... made Mo... down by a... ter shar... flat obje... was pass...

Board... McCredi... tion" s... elimir... the st...

The c... ment ca... limit ra... mile li... "cut-of... public... dren... priv... be b... or th... schoo...

The... so soi... rather... hurs...

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2 1/2 gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

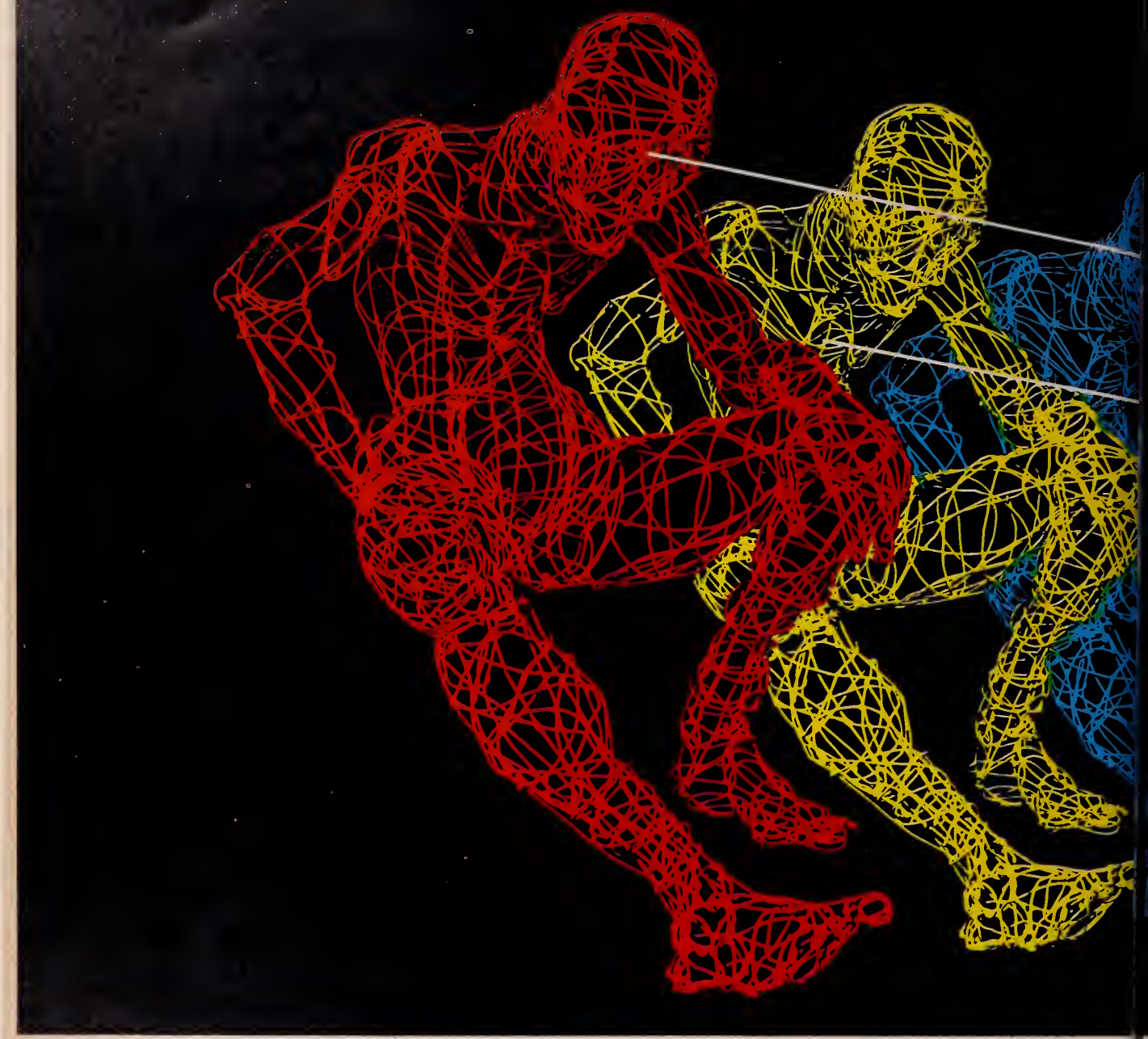
THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

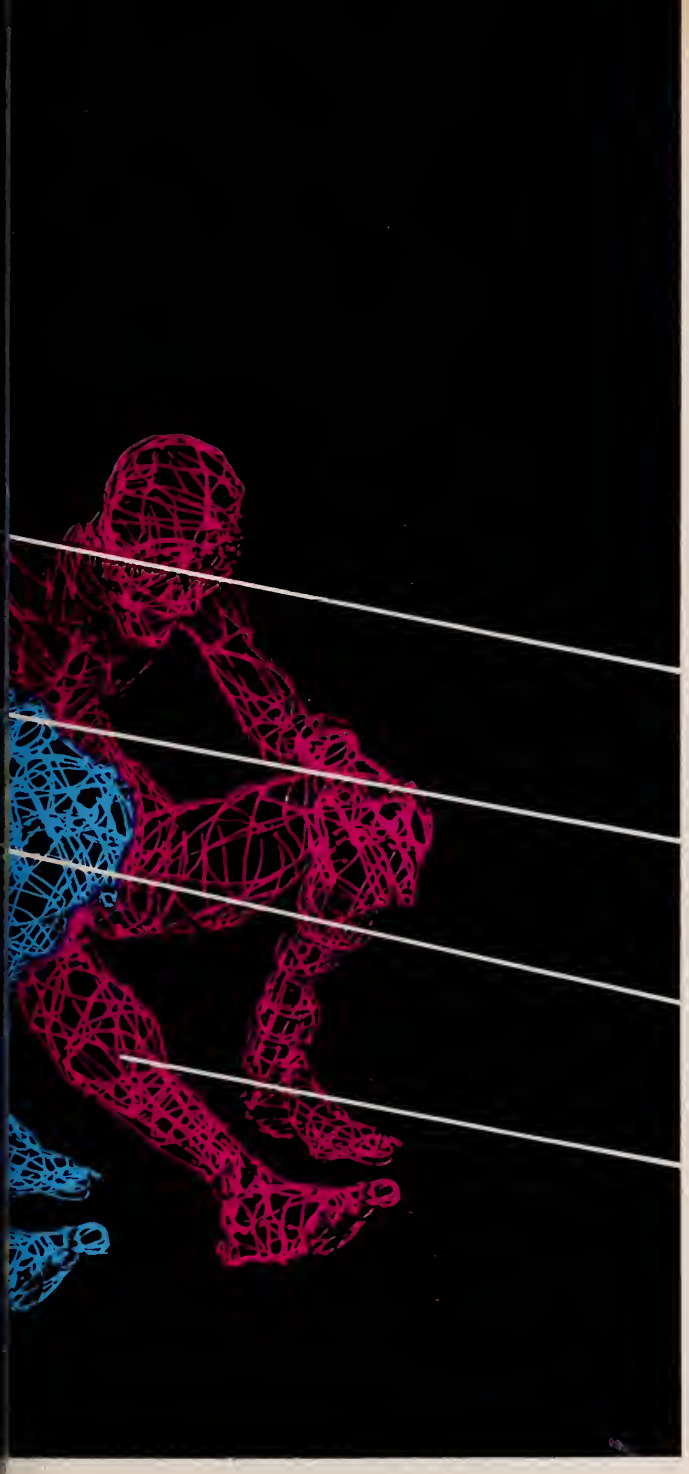
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropr investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adeq vitamin B_{12} therapy may result in hematologic remission but r rological progression. Adequate doses of vitamin B_{12} (parente or oral with potent intrinsic factor as in Trinsicon® [hemat concentrate with intrinsic factor, Lilly]) usually prevent, halt improve the neurological changes.

As with all preparations containing intrinsic factor, resista may develop in some cases of pernicious anemia to the pote tion of absorption of physiological doses of vitamin B_{12}. If re ance occurs, parenteral therapy, or oral therapy with so-ca massive doses of vitamin B_{12}, may be necessary. No single r men fits all cases, and the status of the patient observe follow-up is the final criterion for adequacy of therapy. Peri



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

- **Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.**
- **Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.**
- **Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.**
- **Iron (110 mg.)—treats hypochromic anemia.**

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

Thomas B. Slade | Fifty-two Years in Florida | J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 | P. O. Box 2580 — 1050 W. Adams Street | Jacksonville, Fla. 32203

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

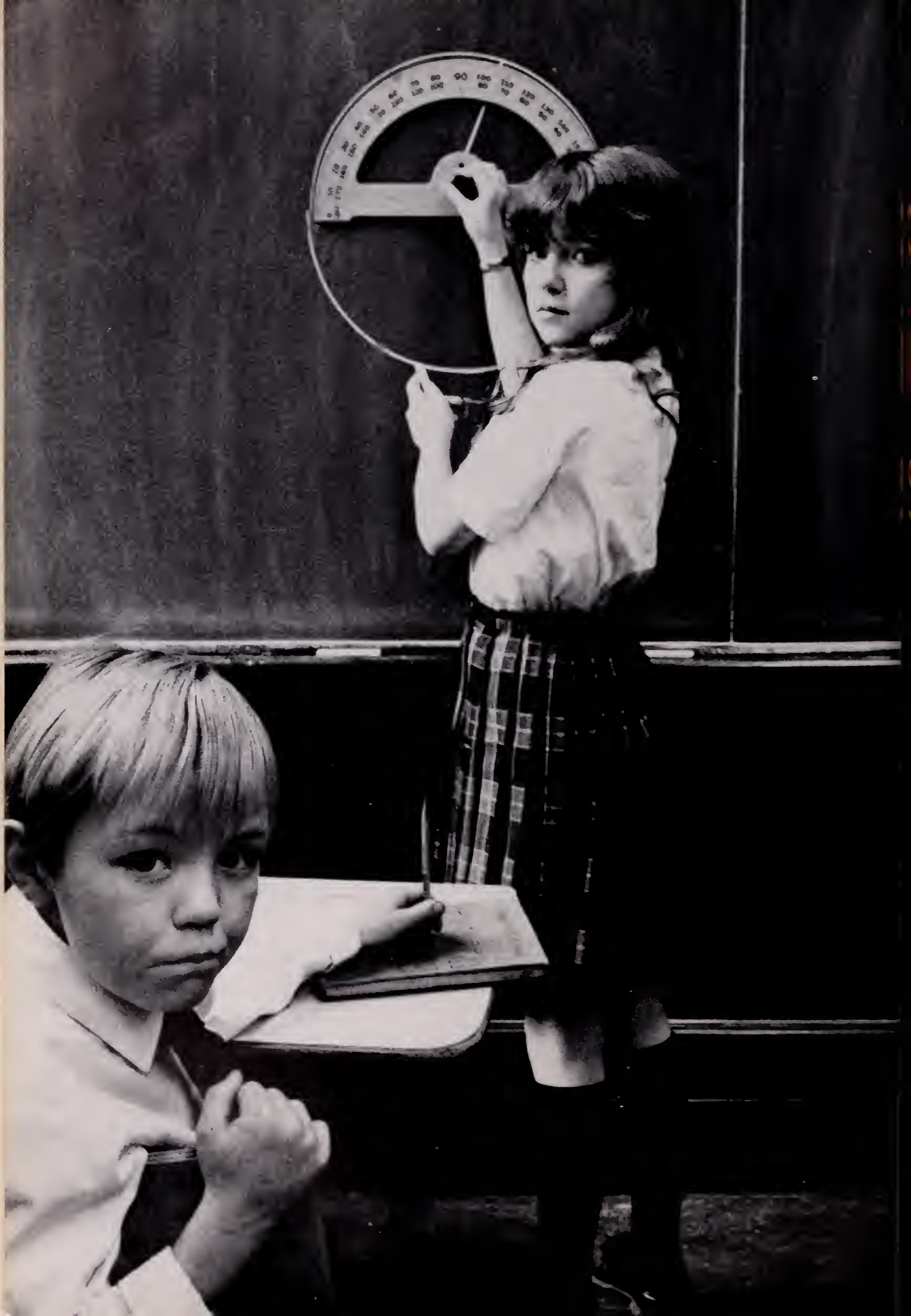
Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 - 324-4882



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

44768

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8

Florida Medical | feature

Republican and Democratic National Conventions

William B. Welch, M.D.

Dr. Welch attended both conventions as a reporter for the Journal. *Reported here are the health planks from each platform as obtained by Dr. Welch at the conventions. He has added relevent comments of his own.—Ed.*

Republican Health Platform

"The information produced by the Johnson-Humphrey Administration is struck hardest in the area of health care. Hospital costs are rising 16% a year—four times the national average of price increases.

"1. We pledge to encourage the broadening of private health insurance plans, many of which cover hospital care only.

"2. [We pledge] to review the operation of government hospital care programs in order to encourage more patients to utilize nonhospital facilities.

"3. Expansion of the number of doctors, nurses and supporting staff to relieve shortages and spread the availability of health care services will have our support.

"4. We will foster the construction of additional hospitals and encourage the regional hospital and health planning for the maximum development of facilities for medical and nursing care.

"5. We also will press for enactment of Republican-sponsored programs for financing of hospital modernization.

"6. New diagnostic procedures.

"7. Also, preventive care to assure early detection of physical impairment, thus fostering good health and avoiding illnesses requiring hospitalization, will have our support.

"Additionally, we will work with the states and local communities to help assure improved services to the mentally ill within the community setting and will intensify research to develop better treatment methods. We will encourage the extension of private health insurance to cover mental illness.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner.

"We especially are concerned with the difficult circumstances of thousands of handicapped citizens who daily encounter architectural barriers which they are physically unable to surmount. We will support programs to reduce where possible and to eliminate such barriers in federal buildings."

Senator Hugh Scott read the following statement before the Republican National Convention on Aug. 6, 1968:

"We must attack the critical problem of rising hospital costs, expand private health insurance plans, increase the number of doctors and nurses, establish cost control programs, modernize hospitals and increase regional planning to avoid duplication of unnecessary facilities. For the mentally ill, programs providing health insurance benefits, better treatment in a community setting

St. Francis Hospital Third Annual Medical-Surgical Seminar

Hospital Auditorium Miami Beach, Fla.

Wednesday and Thursday October 23-24, 1968

"Practical Aspects Of Pulmonary Diseases"

Maurice Segal, M.D., Director of Lung Station, Tufts University

1. Management of Patient with Acute Respiratory Insufficiency
2. Bronchial Asthma, Chronic, Acute Recent Management and Therapy

Edward A. Gaensler, M.D., Professor of Surgery, Boston University School of Medicine

1. Selection of Emphysema Patients for Surgery
2. Mechanics of Breathing, Normal and Abnormal

Asher Marks, M.D., Associate Professor of Medicine, University of Miami School of Medicine

1. The Many Faces of Sarcoid

Marvin Sackner, M.D., Chief, Division of Pulmonary Diseases, Mt. Sinai Hospital, Miami Beach, Florida

1. Interpretation of Arterial Blood Gas Analysis

Panels

1. The Management of Patient with Chronic Respiratory Disease
2. Management of "Status Asthmaticus"
3. Surgical and Medical Advances in Diagnosis and Therapy of Pulmonary Neoplasm

Approved for 8½ elective hours AAGP

Sessions

Wednesday and Thursday
October 23-24, 1968—2-5 & 8-10 P.M.

For additional information: Contact Seminar Office, St. Francis Hospital, Miami Beach, Florida

Telephone: 866-7741

No registration fee.

and increased research are supported."

It is interesting that on presentation of the platform to the first hundred physicians that I personally encountered, only two had any objections to the platform. These two thought the platform statement was indicative of a too advanced socialized program.

Approximately 98% believed the platform to be satisfactory; approximately 60% were enthusiastically in support of the platform as the first realistic platform they had ever read.

Democratic Health Platform

"During the last eight years of the Democratic administration this nation has taken giant steps forward in assuring life and health for its citizens. In the years ahead, we Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medical care. Out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers and the greater use of subprofessional aides all can contribute to the lowering of medical costs.

"We will raise the level of research in all fields of health, with special programs for development of drugs to treat the recurrence of heart diseases, expansion of current task forces in cancer research and the creation of new ones including cancer of the lung, determination of the factors in mental retardation and reduction of infant mortality, development of drugs to reduce the incidence of suicide and construction of health facilities and hospitals.

"Thousands of children die, or are handicapped for life, because their mothers did not receive proper prenatal medical attention or because the infants were unattended in the critical first days of life. Maternal and child health centers, located and designed to serve the needs of the poor, should be established throughout the country. Medicaid programs administered by the states should have uniform standards, so that no mother or child is denied necessary health services. Finally, we urge consideration of a program comparable to Medicare to finance prenatal care for mothers, and postnatal care for children during the first year of life."

Congressman Hale Boggs made a brief statement before the delegates:

"The best of modern medical care should be made available to every American. We support efforts to overcome the remaining barriers of distance, poverty, ignorance and discrimination that separate persons from adequate medical services."

Time and publication deadlines did not permit interview of 100 physicians for comment.

I believe that a comment should be made about the great privilege I have had in making this presentation. It was an opportunity that seldom comes in one M.D.'s lifetime. It is an honor to have met so many of the great men of both parties, and to have had a chance to discuss, and to listen to them discuss, the issues that our nation faces. At times I found that, as a physician, I even could be of service.

The most interesting point concerning the location of the conventions was the ease of communication with the delegates, committee members, press and various congressmen and senators in Miami Beach. Such a condition did not exist in Chicago. The citizens of Miami Beach should be proud of the record they set, not only of security but of all the Miami community personnel who made such a grueling experience a pleasure.

I want to take this opportunity to sincerely thank the editor of the JOURNAL for allowing me to represent our members in this endeavor. I do suggest, however, that any future Florida physician-reporter who is sent to a political convention be trained in a different manner than I have been.

I have good reason to make such a suggestion. On Wednesday, Aug. 28, 1968, I was walking down Chicago's Michigan Avenue (the taxi and bus drivers were on strike) on my way to pick up a copy of Congressman Boggs' statement before the convention of that afternoon. I came upon a crowd of "children" (estimated size of the crowd was between three and five thousand, shouting in unison "Seig Hiel!" and pelleting law officers with small missiles). They were somewhat aboriginal in appearance with long hair and loose-fitting clothes or tunic-like rags for shirts, which opened at the front exposing, usually, an abnormal amount of hair, or, as the case might have been, a flat chest. Both sexes were look-alikes. The average age, except for a very few, was about 25, and the average age for the group leaders was about 40.

While I was observing this strange, group-directed crowd, I became peculiarly anastomosed



A Modern Psychiatric Hospital . . .



This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

Member American Hospital Association
Medicare Provider

in with them (it was difficult to see because the law officers apparently had released some tear gas in self-defense and we were all crying irritation tears) and was swept into the lobby of the Hilton Hotel. Fortunately, I was able to extricate my person from this somewhat odoriferous mass and proceeded to escape to the Blackstone Hotel via the back alley and subterranean passages. Here at the Blackstone, I literally stumbled into the platform clerk of Mr. Boggs' and, of all things and to the best of my knowledge, received the only copy of Mr. Boggs' statement before the platform committee. From this vantage point I observed the riot rather well.

After about two hours, I decided to run for my life back to the Florida delegation which was quartered at the Palmer House, five to six blocks north.

As a result of my experiences, I suggest that the next representative chosen to report the convention activities be *first* sent to Fort Bragg, N.C., for one month of special training with the Green Berets and/or 82nd Airborne prior to the convention date.

▶ Dr. Welch, 7575 S.W. 62nd Avenue, Miami 33143.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

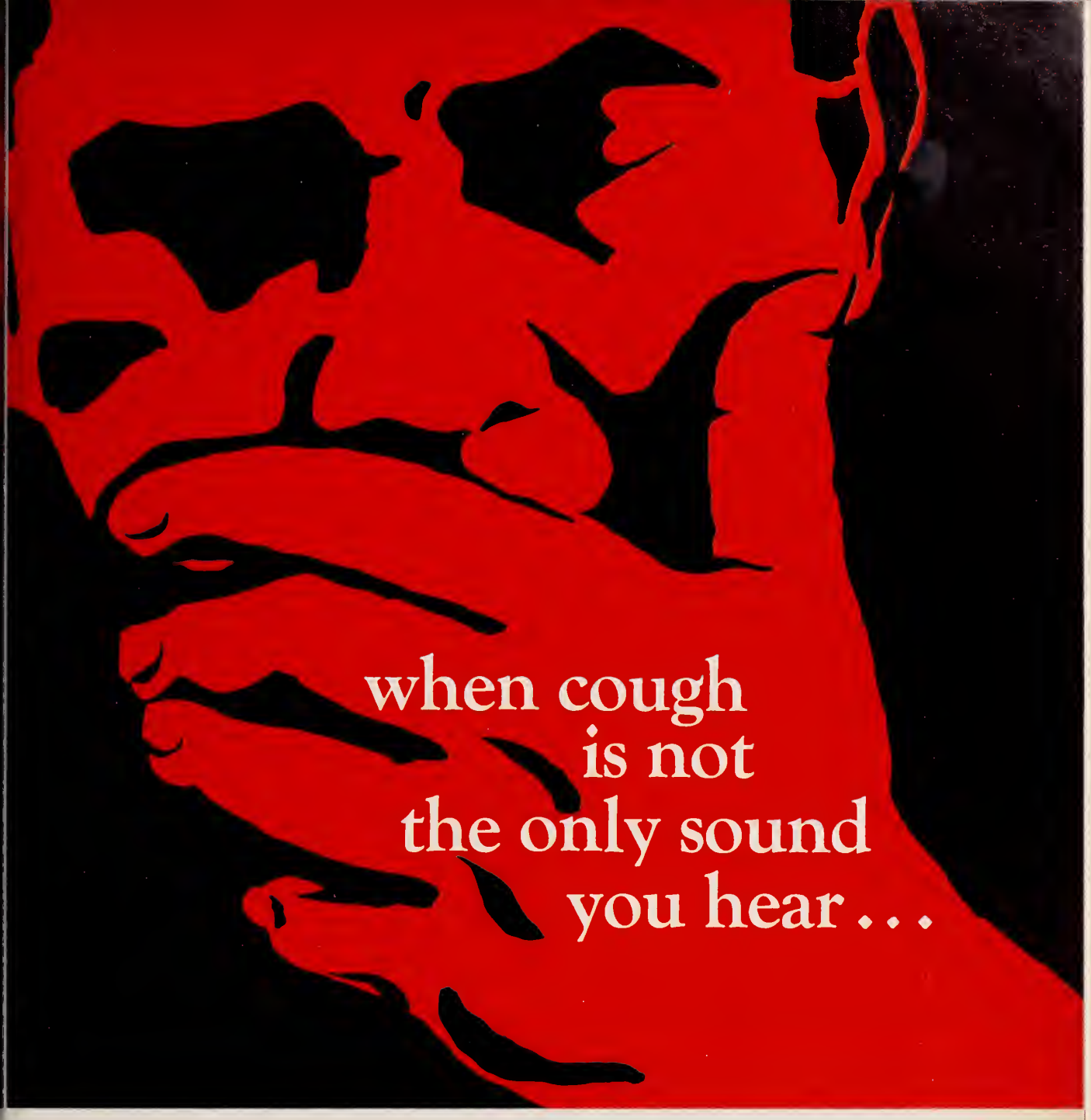
HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticaria type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J.


on call...
Keflin®
Sodium
Cephalothin
Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206



"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

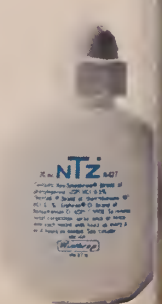
Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Florida Medical organization

The AMA board of trustees mailed the following letter September 9 in explanation of the resignation of Dr. F. J. L. Blasingame as AMA executive vice president—Ed.

I am sending this letter to all members of the House of Delegates, alternate delegates, state medical association presidents and presidents-elect, editors of state medical journals and members of councils and committees of the American Medical Association in order to provide immediate information regarding actions taken by the Board of Trustees at its meeting on September 5-8.

The Board met for 2½ days in executive session reviewing the operational effectiveness of the AMA and related subjects. At the conclusion of this exhaustive, in-depth review, the Board voted unanimously, except for one Trustee who was not present, to retain outside management counsel for the purpose of studying the operational management of the AMA and developing recommendations for improving its overall performance.

There followed a thorough review of the principal staff executives in light of the changing requirements. It was agreed that Dr. F. J. L. Blasingame, executive vice president, was an exceptional man in many aspects of the medical profession; but that the present complex operational needs of the Association require other managerial skills. This was discussed with Dr. Blasingame and it was agreed that he would terminate his duties and responsibilities.

While the management survey is being made and pending its recommendations and the decisions of the Board based on it, Dr. E. B. Howard will serve as acting executive vice president. He has been assistant executive vice president since 1948.

The following press release was issued today:

"Chicago, Sept. 9—Dr. F. J. L. Blasingame, Chicago, is terminating his services as executive vice-president of the American Medical Association, a position he has held since 1958, it was announced jointly today by Dr. Blasingame and the Board of Trustees.

"Dr. E. B. Howard has been named acting executive vice president, Dr. Burtis E. Montgomery, chairman of the board, reported. Dr. Howard has been assistant executive vice-president since 1948.

"Dr. Blasingame left private practice in Texas to assume his AMA position. Previously he had been on the Board of Trustees, and he is a past president of the Texas Medical Association.

"Dr. Howard was active in the public health field in the United States and Peru prior to joining the AMA.

"In view of growing needs and increased functions of AMA since the latest management study was made several years ago, the board authorized retaining a firm of management consultants to conduct an analysis of the AMA operations.

"The Board of Trustees decided that under these circumstances, new administrative direction would be required."

Burtis E. Montgomery, M.D.
Chairman, Board of Trustees



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

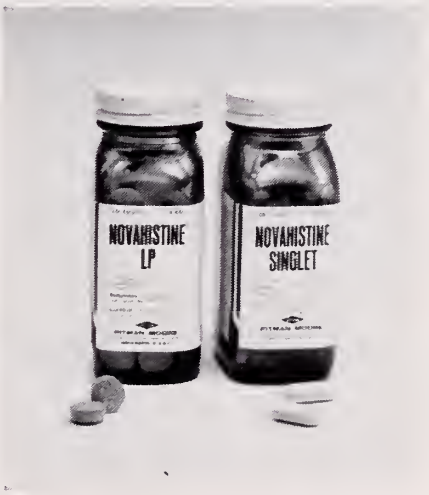
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

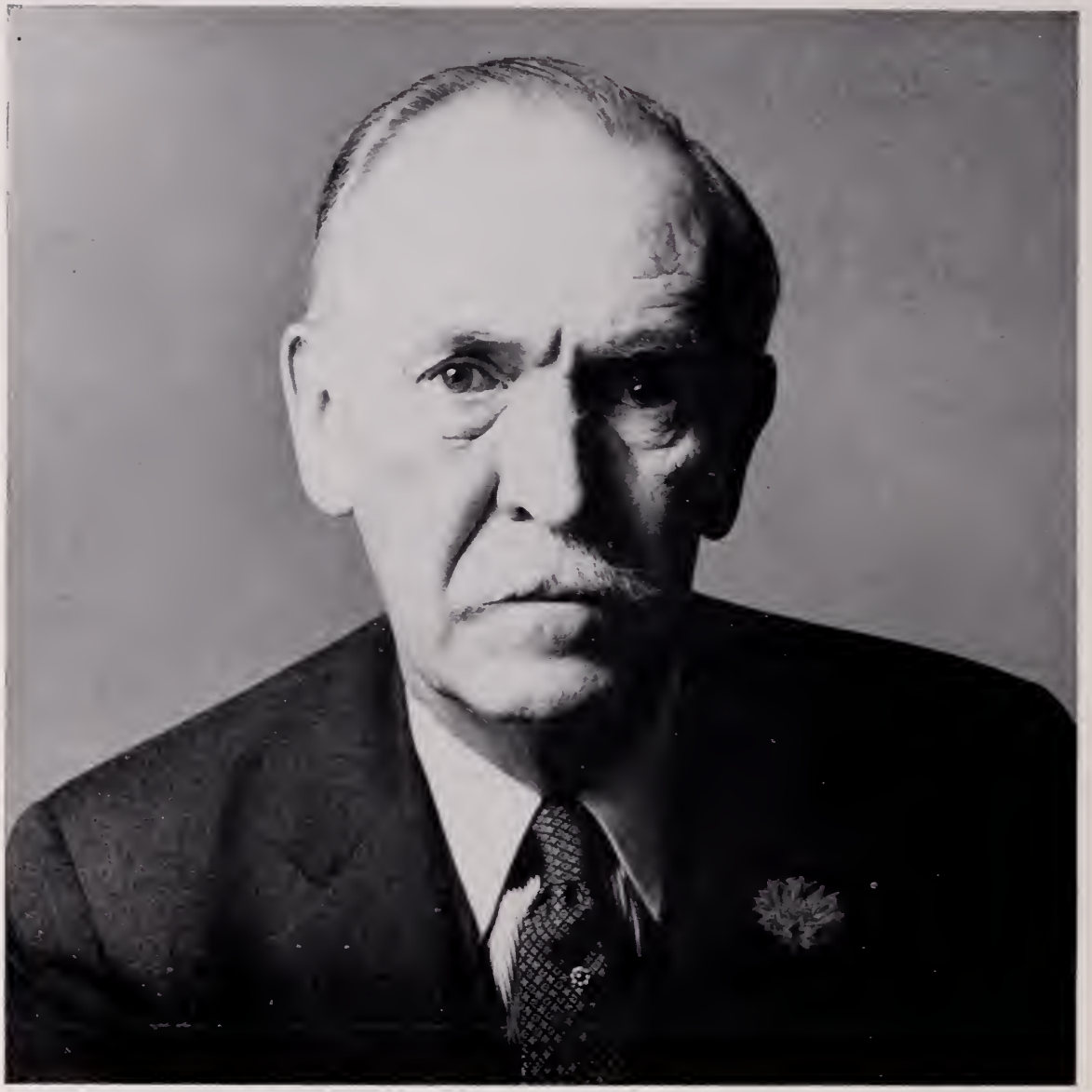
Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. He's tired most of the time. Though there's nothing wrong with him organically, he suffers from general malaise. Lassitude has become his way of life . . . vague aches and pains his major concern.

Such a patient has entered the "Mediatric Age"—that stage of his life in which he's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support he's apt to need. MEDIATRIC is intended to help keep him more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains 15% alcohol†)
†Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound

Ayerst®

AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada 6838



P. L. DODGE MEMORIAL HOSPITAL

M. G. Isaacson, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Florida Medical meetings

FMA Approved Postgraduate Meetings

OCTOBER

4- 5 Otolaryngology Seminar, J. Hillis Miller Health Center, Gainesville

10-12 Pediatric-Cardiology Seminar, J. Hillis Miller Health Center, Gainesville

14-18 Selected Topics in Cardiology, Mt. Sinai Hospital of Greater Miami Auditorium, Miami Beach (Approved 12½ hours accreditation AAGP)

18-19 Florida Industrial Medical Association's Second Industrial Health Conference, Sheraton Motor Inn, Tampa

24-25 Seminar on Obstetrics and Gynecology, J. Hillis Miller Health Center, Gainesville

29-Nov. 1 Sixth Annual Seminar Congress in Cardiology, Mexico City

NOVEMBER

1- 2 Athletic Injuries Seminar, J. Hillis Miller Health Center, Gainesville

7- 9 Today's Hospital Problems: Second Annual Conference, University of Florida and Mound Park Hospital Foundation, Tides Hotel and Bath Club, Redington Beach.

DECEMBER

6- 8 Current Concepts on Management of the Spinal Cord Injured Patient, Americana Hotel, Bal Harbour

9-11 Present Status of Orthotics and Immediate Postsurgical Prosthetic Fitting of the Amputee, Americana Hotel, Bal Harbour

JANUARY

9-12 Sixth Annual Postgraduate Seminar in Anesthesiology, Eden Roc Hotel, Miami Beach

15-18 Seminar in Surgery Art and Science in Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach

15-19 Bedside Interpretation of Laboratory Data, Americana Hotel, Bal Harbour

23-24 Seminar in Obstetrics and Gynecology, J. Hillis Miller Health Center, Gainesville

26-30 Annual Pediatric Postgraduate Course—"Renal and Genitourinary Disorders," Deauville Hotel, Miami Beach

National and Regional Meetings in Florida

OCTOBER

11-19 Society of Clinical Pathologists, Fontainebleau Hotel, Miami Beach

12-18 College of American Pathologists, Fontainebleau Hotel, Miami Beach

NOVEMBER

19-20 Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour

21-26 American Heart Association, Americana Hotel, Bal Harbour

DECEMBER

1- 4 Clinical Convention of the American Medical Association, Miami Beach

4- 6 Academy of Psychosomatic Medicine, Eden Roc Hotel, Miami Beach

9-11 Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton

10-14 American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour

FEBRUARY

13-15 Society of University Surgeons, Fontainebleau Hotel, Miami Beach

MARCH

2- 5 International Anesthesia Research Society, Americana Hotel, Bal Harbour

15-19 American Academy of Allergy, Americana Hotel, Bal Harbour

APRIL

28-May 1 American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour

30-May 3 Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne

MAY

2- 4 American Academy of Psychoanalysis, Deauville Hotel, Bal Harbour

3 American College of Psychiatrists, Deauville Hotel, Bal Harbour

4- 9 American Society for Microbiology, Fontainebleau Hotel, Miami Beach

5- 9 American Psychiatric Association, Americana Hotel, Bal Harbour

22-25 National Tuberculosis and Respiratory Disease Association, Fontainebleau Hotel, Miami Beach

24-26 American Thoracic Society, Fontainebleau Hotel, Miami Beach

pressure
PRESSURE
Sixth Straight Setback
THE NEW YORK
New York Stock Exchange Trading
Drop
DISTRICT COURT
NASSAU COUNTY
Internal Re
310 Lowell Street
PAR
This Vehicle
is illegally parked
violation of Area Park
this ticket) and subje
owners expense as pro
the Commonwealth of M
1, Approved April 10, 19
VIOLATIC
1 NO PARKING ZO
2 RESERVED SPACE
3 BLOCKING DRIVEW
4 EMERGENCY DRIVEW
5 WITHIN 10 FT. OF FIR
6 PARKING WITHOUT PE
7 PARKING IN UNASSIGN
8 PARKING IN LOADING DOCK
9
WARNING

When life's pressures build up blood pressure

in the hypertensive patient

e's pressures and frustrations can often set stage for a rise in blood pressure in the pertensive patient. Emotional fluctuations of od pressure may be especially intensified in hard-driving, aggressive individual who ntinuously pushes himself. Along with your vice to help the patient adjust to living with pertension, you can also prescribe help in form of HYDROPRES.

DROPRES, a combination of two proven anti-pertensive agents, has a mild tranquilizing ect that lets the patient relax as it reduces blood pressure. It alleviates symptoms as-ciated with hypertension, such as headache d tachycardia, that frequently reflect the neral tenseness of the patient.

It's worth noting that potassium loss with HYDROPRES at usual therapeutic doses is usually minimal, and a diet rich in potassium normally avoids serious depletion.

Another point to remember: When other antihypertensive drugs are used adjunctively they must be given at one-half their usual dosage simply because HYDROPRES potentiates the action of such agents. HYDROPRES is contraindicated in anuria and in patients known to be sensitive to hydrochlorothiazide or reserpine.

So, when life's pressures build up blood pressure, consider HYDROPRES to help your hypertensive patient feel more relaxed while under pressure.

HYDROPRES®

ANTIHYPERTENSIVE

HYDROPRES-25:	HYDROPRES-50:
25 mg. hydrochlorothiazide	50 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet	0.125 mg. reserpine per tablet

helps your patient relax as it lowers his blood pressure

For additional prescribing information, please see following page.

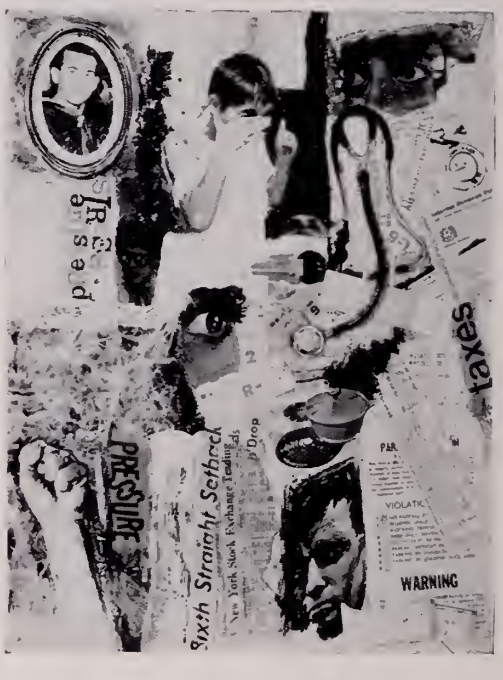
INDICATIONS: Mild to severe hypertension.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to hydrochlorothiazide or reserpine. Nursing mothers. Electroshock therapy; discontinue drug at least 7 days before initiating electroshock therapy.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis. Dosage of other antihypertensive drugs, especially ganglion blockers, must be reduced by at least 50 percent because HYDROPRES potentiates their action. A further reduction in dosage or even discontinuation of the other antihypertensive drugs may be necessary as blood pressure falls. Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery frequently required and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs. The possibility of sensitivity reactions should be considered in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives (including thiazides) and reserpine. Nasal congestion, lethargy, depressed Moro reflex, and bradycardia may appear in infants born of reserpine-treated mothers. Thiazides cross placenta and appear in cord blood. In women of child-bearing age, potential benefits must be weighed against possible hazards to fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS AND SIDE EFFECTS: Hydrochlorothiazide: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive, or patient is receiving parenteral fluids or medication such as digitalis. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant steroid or ACTH therapy, or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypochloremic alkalosis occurs infrequently and is rarely severe. If dietary salt is unduly restricted, especially during hot weather, in severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. Insulin requirements in diabetics may be altered. May produce hyperglycemia and glycosuria in latent diabetics. Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, jaundice. Nausea, vomiting, diarrhea, dizziness, vertigo, paresthesias, purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions may occur. Cutaneous vasculitis precipitated by thiazide diuretics has been reported in elderly patients on repeated and continuing exposure to several drugs. Scattered reports have associated thiazides with pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice. Whenever adverse reactions are moderate or severe, the dosage of thiazides should be reduced or therapy withdrawn. **Reserpine:** Reactions most often reported include excessive sedation, nightmares, nasal congestion, conjunctival injection, enhanced susceptibility to colds, muscular aches, headache, dizziness, dyspnea, anorexia, nausea, increased intestinal motility, diarrhea, weight gain, dryness of mouth, blurred vision, flushing of skin, and pruritus. Skin rash, dysuria, syncope, nonpuerperal lactation, impotence or decreased libido, angina pectoris, other direct cardiac effects (e.g., premature ventricular contractions, fluid

helps your patient relax as it lowers his blood pressure



retention, congestive failure), and CNS (including oc sensitization have been noted. Use cautiously in hyperten patients with coexistent coronary artery disease to avoid cipitous drop in blood pressure. Since reserpine may incr gastric secretion and motility it should be used cautiousl patients with history of peptic ulcer, ulcerative colitis, or o gastrointestinal disorders. May precipitate biliary colic in tients with gallstones, or bronchial asthma in suscept patients. May cause hypotension, including orthostatic h tension. Since significant hypotension and bradycardia develop during anesthesia, discontinue two weeks prio surgery. A Parkinson's disease-like syndrome, usually rev ible with decreased dosage or discontinuance of therapy, been observed. Anxiety, depression, or psychosis may deve Pre-existing depression may be aggravated.

Before prescribing or administering, read product circular package or available on request.

HYDROPRES

ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES
50 mg. hydrochlorothi
0.125 mg. reserpine per t

MERCK SHARP & DOHME | **where today's theory is tomorrow's thera**
Division of Merck & Co. Inc. West Point Pa 19486

We have seen the American city of the future and made it come alive now!

It took us ten years to break the shackles of horse-and-buggy government by voting for Consolidation of our City and County Government, something *your* city must do sooner or later.

As a result Jacksonville, Florida, is the city of tomorrow—*today.*

For years, we were seeing double we had *two* tax assessors, *two* different tax bills, *two* zoning boards. . .some boards in charge of this. . .some in charge of that. The result: Duplication, waste and overlapping authority.

And you know who took it on the chin — the businessmen, the taxpayer, every citizen.

Now at last a dramatic change has taken place.

We have the largest city in the United States (827 square miles) with that absolute essential to city-of-tomorrow planning — *elbow room.*

We are the growing distribution hub for a market of 24,000,000 consumers.

Our half million citizens are excited about our new direction. Our business community is charged with enthusiasm and determined to make Jacksonville the American City of the future.

Professional men and career executives have replaced politicians. Zoning, planning, budgeting, and finance now meet the highest standards of business practice.

And we have *one* man at the top—the Mayor. That's where the buck stops.

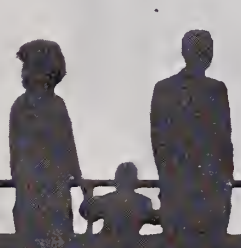
Today Jacksonville, Florida has responsive local government anxious to work with Business and Industry to build "The Bold New City of the South."

As a bonus, our climate is so consistently beautiful it's almost embarrassing, and year-round recreational facilities available to our people are matchless.

Don't wait. Come see us right now. We know you'll get excited about Jacksonville, too.

Hans Tanzler, Mayor

Call, wire or write, Virgil Fox, Director, Committee of 100,
Jacksonville Area Chamber of Commerce
P. O. Drawer 329, Jacksonville, Florida 32201 (904) 353-6161.
He will make all arrangements for your visit—in confidence, of course.



Jacksonville...bold new city of the south

This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial investment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.

Pharmaceutical Manufacturers Association
Pharmaceutical Advertising Council

1155 Fifteenth St., N. W., Washington, D.C. 20005



This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

Florida Medical deaths

Barge, William Jacob, Miami; born Aug. 28, 1898, Newnan, Ga.; University of Georgia Medical Department, 1922; member AMA; died Feb. 18, 1968, aged 70.

Brame, Dorothy Dillard, Orlando; born July 24, 1905, Winston-Salem, N. C.; University of Virginia School of Medicine, 1930; member AMA; died June 12, 1968, aged 63.

Campbell, Meridith Fairfax, Pompano Beach; born Oct. 29, 1894, Lake Geneva, Wis.; Columbia University College of Physicians and Surgeons, 1919; member AMA; died May 25, 1968, aged 74.

Christoffers, Donald Murray, Keystone Heights; born June 8, 1923, Lynbrook, N.Y.; Emory University School of Medicine, 1951; member AMA; died Feb. 18, 1968, aged 45.

Cleveland, Willard Henry, Rockledge; born Jan. 11, 1910, Buffalo, N.Y.; Buffalo School of Medicine, 1935; died Feb. 11, 1968, aged 58.

Collins, Cecil C. Sr., Jacksonville; born Feb. 3, 1886; Memphis Hospital Medical College, 1912; life member FMA; member AMA; died March 26, 1968, aged 82.

Hall, Etheridge James, Punta Gorda; born 1891, Emanuel County, Ga.; Medical College of Georgia, 1914; life member FMA; member AMA; died March 8, 1968, aged 77.

Hart, Dean Whitaker, St. Petersburg; born July 4, 1902, Eureka, Mich.; University of Pennsylvania School of Medicine, 1928; died June 12, 1968 aged 65.

Huntington, Frederick Sargent, Delray Beach; born 1895, Nashville, Tenn.; Harvard Medical School, 1924; died April 12, 1968, aged 72.

Jackson, Kenneth W., Lake Alfred; born 1923, Orlando; St. Louis College of Physicians and Surgeons, 1952; died May 29, 1968, aged 45.

Lyell, Robert Oliver, Miami; born July 14, 1878, Richmond County, Va.; University of Maryland School of Medicine, 1902; life member FMA; member AMA; died Feb. 29, 1968, aged 89.

Magill, John Charles, St. Petersburg; born 1926 in East Liverpool, Ohio; Ohio Medical University, 1954; member AMA; died June 3, 1968, aged 42.

Maines, John Elwood Jr., Gainesville; born Sept. 10, 1901, Lake Butler; Tulane University School of Medicine, 1926; life member FMA; member AMA; died Feb. 17, 1968, aged 67.

Mason, John Henry Jr., Miami; born Sept. 1, 1912, Pittsburgh, Pa.; University of Pittsburgh School of Medicine, 1937; died Feb. 26, 1968, aged 56.

Moore, Dean Crawford, Marathon; born Oct. 15, 1897, Glen Ridge, N.J.; Cornell University Medical College, 1922; died June 24, 1968, aged 71.

Oberlander, Irving A., Coral Gables; born 1900; Long Island Medical College, 1924; died May 7, 1968, aged 68.

Patry, Frederick Lorimer, Bradenton; born Nov. 9, 1897, Toronto, Canada; University of Toronto Faculty of Medicine, 1925; member AMA; died Feb. 24, 1968, aged 71.

Raszus, George C., North Miami Beach; Wayne State University School of Medicine 1953; died August 6, 1968.

Simon, Herbert J. Hollywood; born Nov. 30, 1905, Denver, Colo.; Loyola University School of Medicine, 1930; member AMA; died July 2, 1968, aged 63.

Scolaro, Joseph Domenico, Tampa; born Aug. 8, 1907, Tampa; Tulane University School of Medicine, 1933; member AMA; died March 25, 1968, aged 61.

Towbin, Samuel, Miami; born Sept. 9, 1906, Cripple Creek, Colo.; University of Colorado School of Medicine, 1929; died Apr. 11, 1968, aged 62.

Unger, Jonas, Miami Beach; born June 2, 1891, New York City; Columbia University College of Physicians and Surgeons, 1915; died Apr. 14, 1968, aged 77.

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: Physician to do general practice with two established G.P.s for association and eventual partnership. 35 bed approved JCAH hospital soon to expand—with modern Professional Arts Bldg. and Northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTITIONER with Florida license wanted in Orlando area. Full time opening in county supported outpatient medical clinic. Regular hours, no nights or weekends. Starting salary $18,000; social security, paid insurance, retirement, other fringe benefits. Contact Victoria B. Vacha, M.D., 89 West Copeland Drive, Orlando 32806. Telephone (305) 241-4311, ext. 368.

GENERAL PRACTITIONER for long established group, Hollywood, Florida. Must have Florida license and completed military obligation. Excellent opportunity for an energetic and capable individual. Salary open. Write John Kerwick, Manager, Box 2308, Hollywood, Fla. 33022.

WANTED: General practitioner for association with mixed group. Salary plus percentage and all expenses. Share coverage on day off, weekends, vacations. Guarantee $20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305) 636-4221.

URGENTLY NEEDED: GP to assist established but presently incapacitated physician in operation of 35 bed county hospital. Association or partnership if desired. Compensation open. North central Florida. Write C-850, P.O. Box 2411, Jacksonville, Fla. 32203.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

Specialists

WANTED: Internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Compensation open. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

INTERNIST WANTED: To associate with established internist in greater Miami area. Terms open. Attractive fringe benefits. Large, active practice. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified to associate with two physicians in the greater Miami area. Salary open. Write C-845, P. O. Box 2411, Jacksonville, Fla. 32203.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd., W., Bradenton, Fla. 33505.

WANTED: Internal medicine practice opportunity for board eligible internist with subspecialty interest in Southeastern coastal community. Starting salary $21,000 first year with opportunity for full partnership. Write C-844, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Partnership-internist to head department of large established Lauderdale practice. Excellent facilities, new building with unusual ancillary services. Write C-848, P.O. Box 2411, Jacksonville, Fla. 32203.

PEDIATRICIAN: Board certified or eligible for long established group, Hollywood, Florida. Must have Florida license and completed military obligation. Excellent opportunity for an energetic and capable individual. Salary open. Write John Kerwick, Manager, Box 2308, Hollywood, Fla. 33022.

WANTED: Specialists to staff new medical clinic. Associated eye, ENT, obstetrician-gynecologist, pediatricians, orthopedic surgeon and oral surgeon. For further information and brochures, write Plant City Development Company, 606 N. Plant Ave., Plant City, Fla. 33566.

Miscellaneous

G. P. OR INTERNIST for immediate association in an active practice. Financial and other details open for agreement. Call collect, R. H. Shedd, M.D. (813) 639-1640.

INTERNIST OR GP: North Miami Beach, Fla. $18,000 start—leads to association. Contact Mr. Harold Kwart, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GP OR INTERNIST to associate with three man group, one surgeon and two GP's. Suburban Jacksonville. 30,000 first year to approximately $40,000 in two years of partnership as agreed. Call Dr. M. B. Bergh, (904) 264-9511.

WANTED: GP or general surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

POSITION AVAILABLE: Director of medical education in progressive, modern 700 bed general hospital to administer and coordinate AMA-approved programs composed of rotating internships, and established residencies in surgery, ob-gyn, pathology and general practice. Other residencies are in the development stage. St. Petersburg, Florida offers many activities in cultural, sports and educational realms. Mound Park Hospital is operated by a voluntary not-for-profit corporation. Salary open to negotiation. All replies in confidence. Send curriculum vitae to Charles Aucremann, M.D., Chairman of Education Committee, Mound Park Hospital, 701 Sixth St. South, St. Petersburg, Fla. 33701.

WANTED: Emergency room physician in hospital; to join group of private physicians, 42 hour week, income $20,000 plus. Contact Bruce S. Webster, M.D., 89 W. Copeland Dr., Orlando, Fla. 32806. Phone 241-4311, Ext. 380 or 647-5728.

situations wanted

POSITION WANTED: Indiana University (AOA) radiology resident, age 30, military service completed, seeks radiology group position for July 1969. Have Florida license. Write C-846, P.O. Box 2411, Jacksonville, Fla. 32203.

PATHOLOGIST, CP and PA certified, 14 years department director 300 bed hospital. Director school medical technology. Radioisotopes licenses. Teaching challenge welcomed. Desire relocation South Florida (licensed). Available immediately. Write C-835, P. O. Box 2411, Jacksonville, Fla. 32203.

POSITION WANTED: Internist, now in Michigan, experienced, Florida license, academic and medical education background, over 50 publications, seeks association with successful practitioner, group, or as director of medical education; age 56, good health. Write C-849, P.O. Box 2411, Jacksonville, Fla. 32203.

practices for sale

FOR SALE OR LEASE: Active practice 21 years. Spacious 12 room modernly equipped establishment, new 62 bed hospital in Sebring, Fla. Contact Stanley K. Wallace, M.D., 32 N. Commerce St., Sebring, Fla. 33870. Telephone 385-8640.

real estate

FOR RENT: Medical office complete. New. Rent free to December 1968. Write Suite 111, 4800 N.E. 20th Terrace, Fort Lauderdale, Fla. 33301.

MEDICAL OFFICE FOR RENT: Excellent opportunity. Physician leaving area. 3 treatment rooms, darkroom, lab, carpeted private office, etc. Rental only $210 monthly. St. Petersburg, Florida 33703. Phone 526-3868.

SEMORAN PROFESSIONAL BUILDING: 800 sq. ft. $3.50 per sq. ft. Will finish to suit physician. Ideal for GP or pediatrician. Neat, new, ethical two office building, one dentist, one physician. Close to Winter Park hospital. Phone: B. A. Fieldus, D.D.S. (305) 838-7601 or 838-0113. P.O. Box 168, Fern Park, Fla. 32730.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Florida Medical Association Officers and Council Chairmen

Officers

Jack Q. Cleveland, M.D., Coral Gables, President
Henry J. Babers Jr., M.D., Gainesville, President-Elect
Irving E. Hall Jr., M.D., Bradenton, Vice President
James T. Cook, M.D., Marianna, Speaker of the House
Charles K. Donegan, M.D., St. Petersburg, Vice Speaker
Floyd K. Hurt, M.D., Jacksonville, Secretary-Treasurer
W. Dean Steward, M.D., Orlando, Immediate Past President
W. Harold Parham, Jacksonville, Executive Director

Chairmen

James W. Walker, M.D., Jacksonville, Allied Professions and Vocations
John J. Cheleden, M.D., Daytona Beach, Judicial
Jere W. Annis, M.D., Lakeland, Legislation and Public Agencies
Jack A. MaCris, M.D., St. Petersburg, Medical Economics
James M. Ingram, M.D., Tampa, Medical Services
Richard C. Dever, M.D., Miami, Scientific Activities
William C. Roberts, M.D., Panama City, Special Activities
Joseph G. Matthews, M.D., Orlando, Specialty Medicine
Hawley H. Seiler, M.D., Tampa, Voluntary Health Agencies

Florida Medical advertisers

Anderson Surgical Supply Co. 959
Automated Management 950
Ayerst Laboratories
Mediatric 970-971
Bradley Center 959
Breon Laboratories
Fergon 934
Bristol Laboratories
Tetrex F 953
Burroughs-Wellcome Co.
Empirin 934a
Coca-Cola 956
Conal Pharmaceuticals
Urised 894
Convention Press 932
Dow Chemical Company
A & I Bioproducts 884
Eaton Laboratories
Furacin 929
Geigy Pharmaceuticals
Regroton 944-946
Tandearil 890-892
Tegretol 934a
Tofranil 934a
Glenbrook Laboratories
Bayer Aspirin 893
Highland Hospital, Inc. 956
Hill Crest Hospital 972
Hynson, Westcott & Dunning, Inc.
Lactinex 879
Lakeland Manor 966
Lakeside Laboratories
Norpramin 930
Lederle Laboratories
Achromycin 886a
Achrocidin 962
Achrostatin 948
Declomycin 881
Histoplasmin Tine Test 966
Peritinic 941
Eli Lilly & Co.
Keflin 966a
Trinsicon 958a
V-Cillin K 896
Loma Linda
Soyalac 935
Medical Supply Co. 940
Merck, Sharp & Dohme
Hydropres 974-976
National Drug Co.
Quinamm 939
Parke-Davis & Co.
Benadryl 930a
Dilantin 936
Povan 888-889, 960-961
Pitman-Moore
Novahistine 968-969
P. L. Dodge Memorial Hospital 972
PM of Florida 932
William P. Poythress & Co.
Trocinate 965
Riker Laboratories
Norflex 887
A. H. Robins, Inc.
Cough Calmers 940
Dimetapp 930a
Donnagel 894a
Phenaphen 958a
Robinul Forte 954-955
Robitussin 894a, 895
Roche Laboratories
NCME-TV 951
Valium ..... Back Cover
J. B. Roerig Co.
Tao 932-933
Wm. H. Rorer, Inc.
Emetrol 948
Parepectolin 938
St. Francis Hospital 964
Sandoz
Mellaril 966a
G. D. Searle Co.
Ovulen-21 ..... 930a
Smith, Kline & French Laboratories
Ornade 947
Stamas Boats 886
Strasenburgh Laboratories
Omni-Tuss 966a
Stuart Co.
Mylanta 958a
Surgical Supply Co. 959
Tucker Hospital, Inc. 934
Warner Chilcott Laboratories
Sinutab 878
Winthrop Laboratories
NTZ 966a



ready for bed..

but not for sleep

...because psychic tension may not stop at night

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance

depressed, or with latent depression, or wi suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclu ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplop hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurre speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such acute hyperexcited states, anxiety, halluci tions, increased muscle spasticity, insomn rage, sleep disturbances, stimulation, hav been reported; should these occur, discon tinue drug. Isolated reports of neutropenia jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®
(diazepam)

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

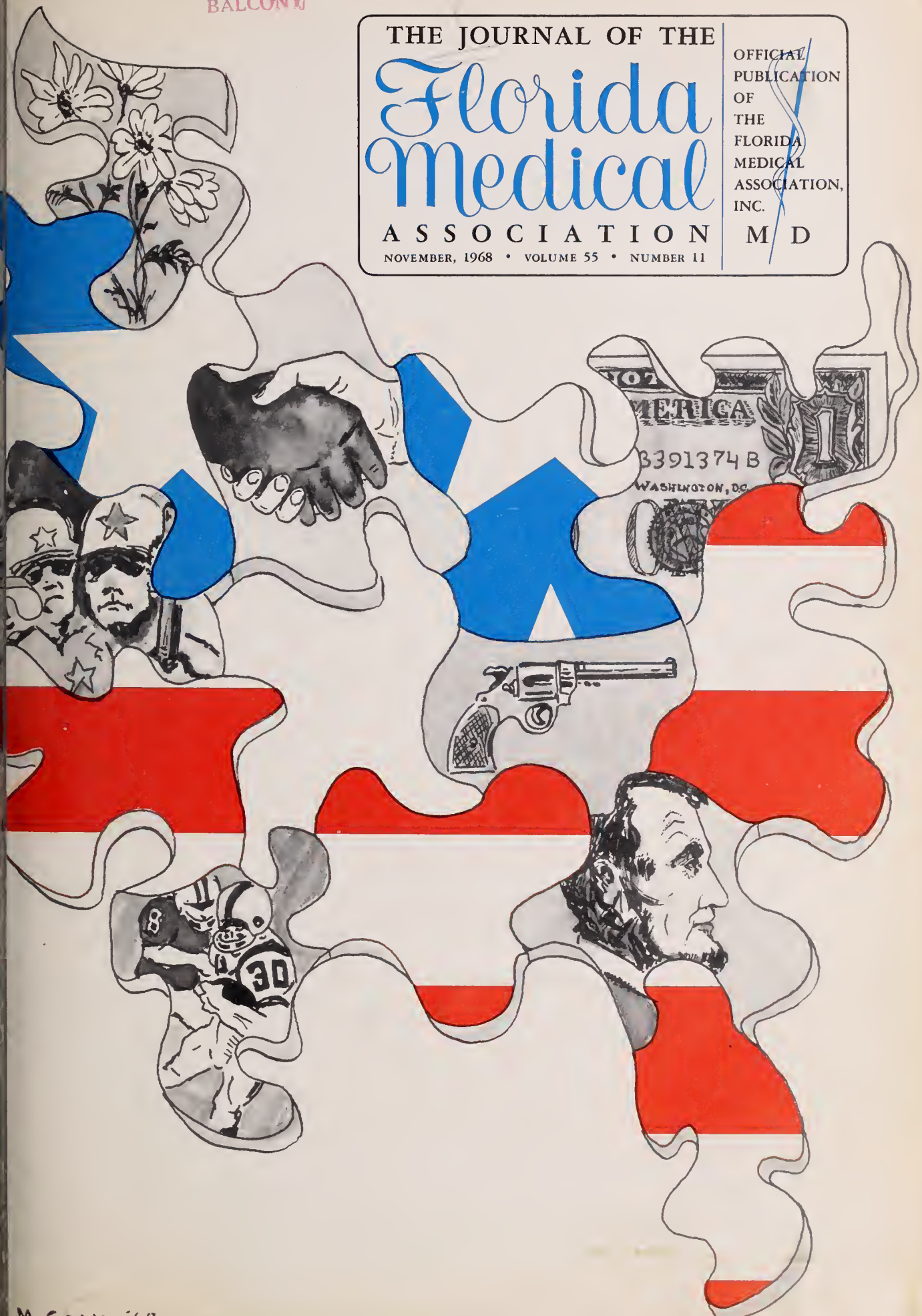
NY ACADEMY MED LIBRARY
2 EAST 103RD ST
NEW YORK NY 10029

BALCONY

THE JOURNAL OF THE
Florida Medical ASSOCIATION
NOVEMBER, 1968 • VOLUME 55 • NUMBER 11

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M D



M. Grove '68



You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y. in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

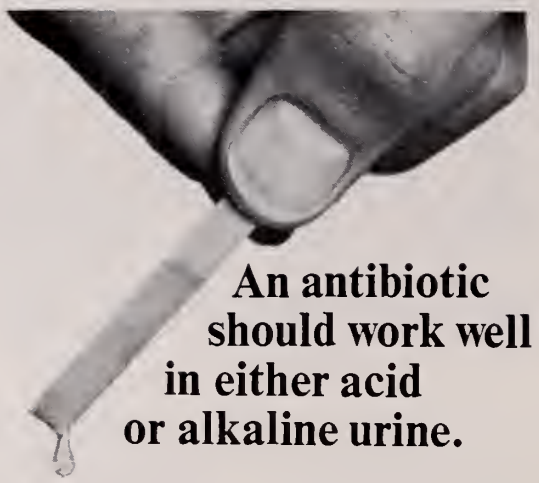
- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. HW&D BALTIMORE, MARYLAND 21201

(LTR23)



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

THE JOURNAL OF THE
Florida Medical ASSOCIATION
NOVEMBER, 1968 • VOLUME 55 • NUMBER 11

scientific

The Work of the Winter — Pneumonia 1003
N. Joel Ehrenkranz, M.D.
Subclavian Steal Syndrome 1005
Donald L. Arey Jr., M.D.
Editorial Comment 1009
Francis N. Cooke, M.D.
Self-Evaluation of Post-Hospital Adjustment by 131 Discharged Psychiatric Patients 1010
William C. Ruffin Jr., M.D., Sidney B. Denman, Ph.D., and Barbara Guyon, B.A.
Multiphasic Screening — Report of a Demonstration Project in Florida 1012
Joseph E. Frydman, M.D., James E. Fulghum, M.D., Joel S. Glaser, M.D., and Francis R. Meyers, M.D.
Surgical Relief of Intractable Pain Due to Cancer 1014
Irwin Perlmutter, M.D. and David Fairman, M.D.
Cesarean Hysterectomy Experience 1016
Donald R. LaPlatney, M.D. and James A. O'Leary, M.D.
Editorial Comment 1018
Sam W. Denham, M.D.

sections

Comment 1025
Editorial 1023
Medicolegal 1043
President's Page 993

information

Advertisers 1058
Classified 1056
Florida Medical Association Officers and Council Chairmen 1055
Information for Authors 991
Meetings 1024

Owned and published by the Florida Medical Association, Inc., P.O. Box 2411, Jacksonville, Florida 32203. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tympanic membrane is perforated) and otitis externa both respond to the bactericidal action of Furacin® (nitrofurazone) in Furacin-HC (nitrofurazone-hydrocortisone) Otic. Its broad antibacterial spectrum includes most of the organisms encountered in surface infections (but only certain strains of Pseudomonas). The hydracortisone component in Furacin-HC Otic affords rapid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble base of Furacin-HC Otic permits free drainage and provides a hygroscopic vehicle.

Designed to please and protect the patient

Topical Furacin-HC Otic lets you reserve systemic preparations for systemic infections. It rarely irritates inflamed epithelial surfaces, and cross resistance or cross sensitization with antibiotics does not occur. In addition, nonmacerating, odorless Furacin-HC Otic softens wax to facilitate removal of cerumen.

Also available: Furacin® Otic (nitrofurazone with nifuroxime and diperadan HCl). The wide antibacterial range of Furacin is augmented by the antimycotic activity of Micafur® (nifuroxime). Diperadan hydrochloride, an efficient local anesthetic, promptly subdues pain and itching. Indicated in bacterial otitis externa, otomycosis or bacterial otitis media (when the eardrum is perforated).

Precautions: Sensitization to nitrofurazone may occur with prolonged use and is more likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Contraindications: The usual contraindications for preparations containing hydrocortisone should be observed, such as tuberculous lesions of skin or ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand of nitrofurazone, and 1.0% hydrocortisone acetate in a water-soluble hygroscopic base of glycerin and polyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand of nitrofurazone, 0.375% Micofur®, brand of nifuroxime, and 2% diperadan hydrochloride dissolved in water-soluble, nondrying, hygroscopic polyethylene glycol.



™Originators and Developers of The Nitrofurans
EATON LABORATORIES
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone / hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl



Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number, 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P.O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE
Florida Medical
ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

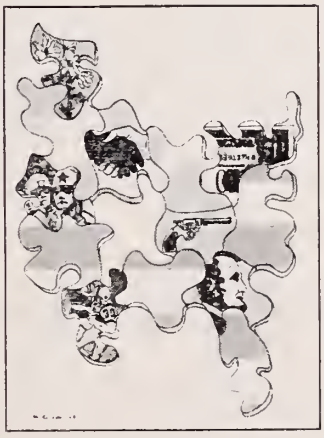
OSCAR W. FREEMAN, M.D.
Assistant Editor

RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

LOUISE RADER
Assistant Managing Editor



NOVEMBER COVER

The new President of the United States, elected this month, has a real puzzle to fit together for our country. Miss Martha Grove, one of our fine younger citizens, gives us her view of the puzzle.



When she gets a bacterial infection, think of Tetrex-F.®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



The AMA and You

As the American Medical Association is holding its 22nd Clinical Convention in Miami Beach in December (see page 1038), it seems appropriate to point out a few things about the AMA, as well as our Florida Medical Association.

The great bulk of the work done by both organizations is of a quiet nature that never reaches public attention. This work, however, affects the health and welfare of every person in America. The official purpose of the AMA is to "promote the science and art of medicine and the betterment of public health." Specifically, the AMA sponsors 1,000 scientific meetings a year, including two national conventions. Weekly, it publishes a medical newspaper and the world's leading medical journal. Its representatives serve on committees which inspect hospitals and medical schools, suggest the form of health texts for the public schools and help Medicare to work as smoothly as possible.

The AMA helps its members practice medicine more effectively by making available its many resources including its medical library and medical films. It publishes ten specialty journals every month. It has a legal department and a placement bureau which is available to all its members. There are many AMA field representatives whose sole obligation is to help and coordinate efforts between state and county associations and the AMA. Most of the time, even when AMA representatives testify before congressional committees on matters of health and health legislation, there is no national publicity. The record shows that year after year the AMA favors many more health bills in Congress than it opposes. It is only when the AMA is in opposition to a prominent bill that it makes news. Though it favored national legislation to support medical care of the needy, it opposed Medicare and thereby gained a host of vocal foes. The AMA opposes "health" foods and diet fads and, as a result, has won the enmity of some manufacturers, authors, lecturers and book publishers. It opposes chiropractic as an unscientific cult, so chiropractors speak unkindly of it.

As Dr. Ernest B. Howard, AMA acting executive vice-president, pointed out recently in an address in Chicago, "The American Medical Association is now engaged in a massive program to stimulate state and local medical societies—and citizens—to participate in programs designed to help the medical schools in their communities."

All of this should stimulate us to attend the AMA Clinical Convention in December and become working members of organized medicine.

* Some of the data cited in this message were found in Today's Health, a monthly family health and general interest publication of the AMA.

Jack R. Cleveland

Need a head mirror?



Ask your lab supply man!

Need a placebo?



Phone your pharmacist!

Need optical services?

GUILD Rx OPTICIANS ®

Call on an expert —

YOUR GUILD OPTICIAN!

Your local Guild Optician has the special skills and experience with which to properly serve your patients in the area of optical services. He is, in short, an expert, and here's why:

The Rx you write must be accurately filled and properly adjusted for optimum results. *Your Guild Optician is highly skilled at both.*

Patients with special problems demanding frequent adjustment require special handling — time, patience and infinite care must be devoted to these cases. *Your Guild Optician has these qualities in full measure.*

Your patients must be able to count on the optician to routinely handle any problem of after-service and repair for the life of the glasses they wear. *Your Guild Optician is always available with his skills to help your patients.*

In serving you, the Guild Optician also has a stake in the welfare of your patients; depend on his expert services and experience to be sure your patients are getting the best possible results from the prescriptions you write! *Guild of Prescription Opticians of Florida.*

USING GUILD SKILLS AND EXPERIENCE TO SERVE YOUR PATIENTS

In peptic ulcer: the antacid puzzle



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

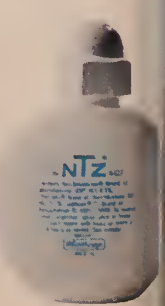
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria, serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

44758

Is it depression?

She says "I'm always on edge..."



...but her other symptoms: depressed mood, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl

(AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompany ing depression.

Contraindications: Glaucoma and predisposition to urinary re tention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within th first few days of therapy. Patients should be warned agains driving a car or operating machinery or appliances requirin alert attention. When depression is accompanied by anxiet or agitation too severe to be controlled by ELAVIL HCl alone a phenothiazine tranquilizer may be given concomitantly Suicide is always a possibility in mental depression and ma remain until significant remission occurs. Supervise patient closely in case they may require hospitalization or concomitan electroshock therapy. Untoward reactions have been reporte after the combined use of antidepressant agents havin varying modes of activity. Accordingly, consider possibilit of potentiation in combined use of antidepressants. Mono amine oxidase inhibitor drugs may potentiate other drugs an such potentiation may even cause death; permit at least tw weeks to elapse between administration of two agents; i such patients, initiate therapy with ELAVIL HCl cautiously wit gradual increase in dosage required to obtain a satisfacto response. Caution patients about errors of judgment due t change in mood, and that the response to alcohol may b potentiated. May provoke mania or hypomania in manic-de pressive patients.

Side effects include drowsiness; dizziness; nausea; excitement hypotension; fine tremor; jitteriness; weakness; headache heartburn; anorexia; increased perspiration; incoordination allergic-type reactions manifested by skin rash, swelling o face and tongue, itching; numbness and tingling of limbs including peripheral neuropathy; activation of schizophreni which may require phenothiazine tranquilizer therapy; epi leptiform seizures in chronic schizophrenics; temporary con fusion, disturbed concentration or, rarely, transient visua hallucinations on high doses; evidence of anticholinergic ac tivity, such as tachycardia, dryness of the mouth, blurring o vision, urinary retention, constipation; paralytic ileus; jaun dice; agranulocytosis.

Careful observation of all patients is recommended. The anti depressant activity may be evident within 3 or 4 days o may take as long as 30 days to develop adequately, and lac of response sometimes occurs. Response to medication wil vary according to severity as well as type of depression pres ent. Elderly patients and adolescents can often be manage on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., an 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injectio ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. ami triptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, an 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 1948

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg., chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Florida Medical | scientific

The Work of the Winter — Pneumonia

N. Joel Ehrenkranz, M.D.

The winter will soon be upon us and the work it brings will include diagnosis and management of pulmonary infection. Salient distinguishing features of bacterial and nonbacterial pneumonias are presented in Table 1. Signs and symptoms of disease in the chest characterize bacterial pneumonia, whereas signs and symptoms of more generalized disease occur in the nonbacterial infections. Bacterial and nonbacterial pneumonias may have a similar chest x-ray appearance of lobar or segmental bronchopneumonia with "air bronchograms." However, pleural reaction and bilateral basal bronchopneumonia, common features of bacterial infection, are uncommon in nonbacterial pneumonias. In the nonbacterial infections, either diffuse bilateral pneumonia fanning from the hilar regions or segmental bronchopneumonia involving one lobe is the usual finding.

Host Factors

Immunity does decrease susceptibility to some bacterial and nonbacterial respiratory infections, but the immunity is highly specific and is effective only for individual strains of microorganisms. However, host factors other than immunity play an important role in bacterial pneumonias. Bacterial infections tend to occur in persons with predisposing conditions. Infections with pneumococci, staphylococci or enteric bacteria are found in association with one or another of the following: underlying pulmonary obstruction, atelectasis, bronchitis, bronchiectasis, decreased cough reflex, diminished bronchial ciliary action, mucoviscidosis, sickle cell disease, congenital heart disease, immunoglobulin deficiency or antecedent virus infection. Hence, the diagnosis of bacterial pneumonia tells the physician to search further than bacteria for cause. By contrast, conditions such as pregnancy, heart disease or chronic lung disease may affect the severity of a nonbacterial illness, but most cases of influenza, adenovirus or mycoplasma infections occur in persons with no pre-existing illness.

Prevention

Specific vaccines can prevent or minimize infection with respiratory viruses. Pregnant women, persons with chronic lung or heart disease and elderly persons should be immunized against influenza. The vaccine must contain antigens of current infecting strains to be effective. Children best acquire their immunity naturally to respiratory viruses such as influenza.

The conflicting reports of efficacy of broad spectrum antibiotic therapy in preventing bronchitis or acute flareups of chronic respiratory disease probably reflect studies of patients with different etiologies of respiratory infection. Bronchitis can be viral, mycoplasmal or bacterial in origin—singly or in combination. Only susceptible bacteria and mycoplasma will be affected by antibiotics such as tetracycline, oleandomycin, erythromycin and lincomycin, in dosage of 250 mg. two to three times a day.

Dr. Ehrenkranz is professor, Department of Medicine, University of Miami School of Medicine, Miami.

Table 1.—Comparison of Bacterial and Nonbacterial Pulmonary Infection

	Bacterial	Nonbacterial
Infecting agents	pneumococci, streptococci, staphylococci, enteric bacteria, hemophilus	mycoplasma, bedsonia, rickettsia, myxoviruses, adenoviruses, picornaviruses
Clinical picture	chest findings predominate: grunting respirations prominent physical findings of consolidation—rusty or purulent sputum with many bacteria	generalized findings predominate: headache, myalgia retroorbital pain, hacking nonproductive cough, cyanosis or tachypnea out of proportion to physical findings; if sputum is present there are few bacteria
Chest x-ray	lobar involvement with pleural reaction or bilateral bronchopneumonia is usual	segmental unilobar bronchopneumonia or diffuse nodular pneumonia fanning from hilar region is usual; pleural reaction rare
Physiologic changes	unequal perfusion and ventilation first few days as a result of shunting through involved lung, later on as a result of decreased compliance	alveolar-capillary block—may persist for months after x-ray has cleared
Microbiologic studies	many polymorphonuclear cells and large numbers of pneumococci enteric bacteria, staphylococci hemophilus in sputum smear; serologic studies generally not available or useless	few or no bacteria in sputum smear, influenza, adenovirus, mycoplasma, bedsonia, etc. found in tissue culture; serology useful
Host factors	predispose to infection	affect outcome, but do not predispose to infection
Antibiotic therapy	a penicillin, cephalosporin or erythromycin for gram-positive bacteria and hemophilus; kanamycin or chloramphenicol for enteric bacteria	erythromycin or a tetracycline for bedsonia or mycoplasma

Therapy

Pneumococcal pneumonia is treated with 300,000 to 600,000 units of penicillin G parenterally two to four times daily for five to seven days. At the outset, treatment of persons who may have staphylococcal or enteric bacterial infections —debilitated persons or those with diabetes mellitus, alcoholism, chronic lung or cardiac disease—should include an isoxazolyl penicillin for penicillinase-producing bacteria such as oxacillin or nafcillin, in dosage of one gm. parenterally every six hours, along with kanamycin 250 mg. intramuscularly for a day or two. Alternatively, cephalothin intravenously in dosage of one gm. every four to six hours may be administered. After bacteriologic results are obtained, the unnecessary antibiotic can be stopped or therapy changed. For treatment of the penicillin-allergic patient, cephalothin or erythromycin can be substituted for penicillin. Oral medication should be used as soon as the patient can take medication by mouth.

Erythromycin or tetracycline in dosage of 250 mg. orally every six hours is effective in treatment of mycoplasma, psittacosis-ornithosis, and *Coxiella burneti* (Q fever) infections. Fever will disappear and well-being will return fairly soon after the start of treatment; however, cough and the carrier state of the infectious agent may persist for several weeks or longer.

Supportive treatment is necessary—oxygen, fluids, tracheal suctioning and ventilatory assistance may be useful. Studies of blood gases, electrolytes and pH are part of a good workup.

▶ Dr. Ehrenkranz, P.O. Box 875, Biscayne Annex, Miami 33152.

Subclavian Steal Syndrome

Report of Six Cases

Donald L. Arey Jr., M.D.

The condition referred to as the subclavian steal syndrome was first described by Contorni[1] in 1960, and was first defined by Reivich[2] in 1961. The basic pathologic process is an occlusion or a stenosis of the subclavian artery proximal to the origin of the vertebral artery. The result is a reduction in pressure in the distal subclavian artery which may produce a reversal of the normal direction of blood flow in the ipsilateral vertebral artery. This has the effect of increasing the blood flow to the arm, but at the expense of decreasing the blood supply to the brain. To this phenomenon the term "subclavian steal" has been applied.

Since the syndrome was first described, more than 100 cases have been described in the literature. It is likely that this number will increase in the future with the increasing use of arteriography and with the higher index of suspicion of the condition.

This paper reports upon six case histories of patients admitted to Orange Memorial Hospital since 1961. The following representative case history is presented in detail.

Report of Case

A 48-year-old white woman was hospitalized on Feb. 4, 1968 with a history of being involved in an automobile accident five years prior to admission. At the time of the accident she sustained trauma to the left shoulder. She apparently had little difficulty following the trauma, except for mild pain that radiated down the left arm. Shortly thereafter, however, intermittent claudication developed in her left arm. Next gradual and increasing weakness developed in the left arm; transient attacks of dizziness, and generalized headache also were present. She denied any other neurologic symptoms. She had been told at one time that her radial pulse was weaker on the left than on the right.

Physical examination revealed an obese white woman in no acute distress. Blood pressure in the right arm was 130/80 mm. Hg. and in the left arm was 60/30 mm. Hg. The radial pulse was strong on the right but barely palpable on the left. Carotid pulses were strong and equal bilaterally. A loud, grade III/IV left supraclavicular bruit was heard. Neurological examination revealed marked weakness and slight wasting of the musculature of the left forearm. No other abnormalities were noted in the neurological examination. Laboratory study results were all within normal limits.

A transfemoral thoracic aortogram revealed marked narrowing of the subclavian artery at its origin extending three centimeters distally. Late films revealed a retrograde filling of the vertebral artery on the left side down to the subclavian artery.

On Feb. 19, 1968 the left subclavian artery was surgically explored through thoracotomy of the left side and a 3 cm. fibrotic plaque was found in the wall of the proximal subclavian artery between its origin and the junction with the left vertebral artery.

An endarterectomy was performed, and a saphenous vein patch graft applied. Postoperatively, strong pulsations were noted in the left radial artery, and the patient noted marked improvement in her previous complaints. She was discharged one week later without complaints referable to the neuromuscular system. Follow-up to date has revealed no return of her previous symptoms.

Comment

The patients herein reported upon range from age 39 to age 57. Four of the six patients are female. Five out of the six showed lesions of the left side. All patients reported symptoms of dizziness and weakness or claudication of the involved arm. One patient experienced periodic focal motor seizures, a rarely reported symptom. One patient underwent endarterectomy alone; another underwent endarterectomy with saphenous vein patch graft. Three underwent aortosubclavian bypass. Of these three, a dacron graft was used in two and an autogenous vein graft was used in the third. One patient was lost to follow-up after refusing surgery. Four cases were related to arteriosclerotic plaque formation, the most common etiological factor. One case was related to trauma and one caused by far advanced carcinoma of the apex of the lung. No operative deaths were noted. All patients operated upon experienced excellent results.

From the Department of Surgery, Orange Memorial Hospital, Orlando.

Discussion

The subclavian steal syndrome is more commonly reported in males in the ratio of three to one. It generally is a disease of middle life, but has been reported in a 4-month-old infant and in a 72-year-old male patient.[3] As of 1966, a total of 110 cases had been reported in the literature.

The etiology of the localized stenosis or occlusion most commonly is related to an atherosclerotic plaque, but other varied etiologic factors have been noted. It may be produced by direct trauma to the proximal subclavian area. A case has been reported in which a luxation of the first rib, related to trauma, produced a compression of the subclavian artery against the left clavicle with a resultant subclavian steal.[4] It has been noted in far advanced carcinoma of the apex of the lung with invasion of the superior chest wall. Dardik et al[5] reported one case caused by an embolus to the proximal subclavian artery. Massumi[6] described a congenital atresia of the left subclavian artery producing a steal of the left side. It may follow the Blalock-Taussig procedure, where the distal pulmonary artery is anastomosed to the proximal subclavian artery; Folger et al[7] reported subclavian steal developing in seven of twelve patients that underwent the Blalock-Taussig procedure. At least one case of bilateral subclavian steal has been reported, the patient showing a severe degree of symptoms.[8]

Clinical Findings

The most common symptoms reported are intermittent dizziness and decrease in visual acuity.[9] Claudication and easy fatigability are the most common complaints referable to the arm. Any symptoms related to basilar insufficiency may be noted, including vertigo, syncope, nausea, diplopia or weakness. Headache, focal seizures, motor and sensory disturbances are seen less commonly. Rarely, one may see dysarthria, aphasia, loss of memory, confusion, olfactory hallucinations[10] or episodic blindness.[11] Neurologic

Table 1.—Six Patients Admitted to Orange Memorial Hospital with Definite Subclavian Steal Syndrome

Patient	Age	Sex	R or L	Symptoms	Procedure	Type of Obstruction	Results	Follow-u
1.	49	F	R	Dizziness, vertigo, syncope, weakness and fatigability of the right arm	Endarterectomy	Arteriosclerotic plaque	Good	No return of symptor
2.	39	F	L	Headache, dizziness, nervousness, nausea, weakness of left arm, decreased left pulse	Thoracotomy with left aortosubclavian bypass (dacron)	Arteriosclerotic plaque	Excellent	No return of symptor
3.	40	M	L	Syncope, focal motor seizures, dysphasia, weakness of left arm, decreased left pulse	None	Carcinoma of left lung	—	—
4.	48	F	L	Dizziness, headache, claudication of left arm with weakness, decreased left pulse, supraclavicular bruit on left	Endarterectomy with saphenous vein patch graft	Traumatic fibrotic plaque	Excellent	No return of symptor
5.	39	M	L	Episodic dizziness, weakness of left arm, decreased left pulse	Thoracotomy with left aortosubclavian bypass (dacron)	Arteriosclerotic plaque	Excellent	No return of symptor
6.	57	F	L	Headache, dizziness, diplopia, weakness, pain and numbness of left arm, decreased pulse on left	Thoracotomy with left aortosubclavian bypass graft using saphenous vein	Arteriosclerotic plaque	Excellent	No return of symptor



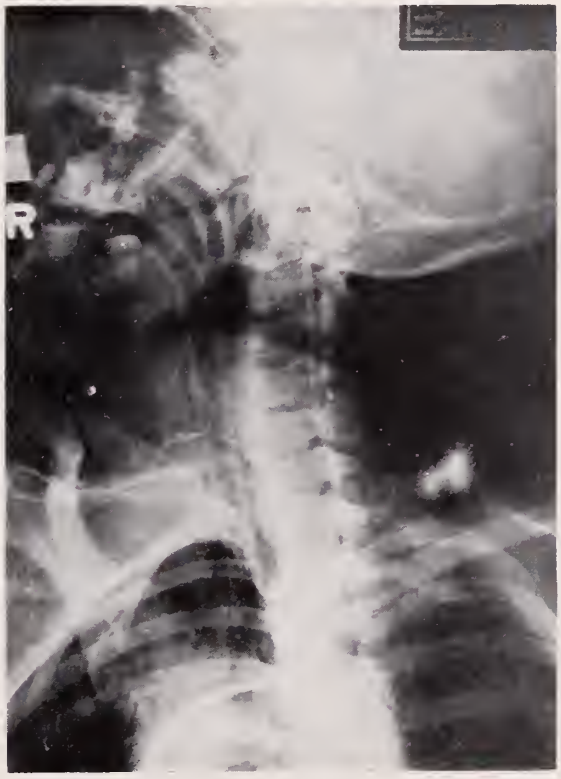
manifestations may be caused by ischemia or infarction of any structure whose blood supply is derived from the vertebrobasilar system, including the upper spinal cord, brain stem, cerebellum, thalamus, labyrinth, cochlea or occipital lobes.

On physical examination, one most commonly sees a greatly reduced, or absent, radial pulse. A difference of 40 mm. Hg. is suggestive, but not diagnostic. Careful auscultation may reveal a supraclavicular bruit. Muscle wasting and marked decrease in strength may be noted in the involved arm. Patients with a definite radiographically-demonstrated subclavian steal may or may not be symptomatic. If symptoms are present, they may involve the arm, the brain, or both.[12]

Diagnosis

Diagnosis is best confirmed by arteriography with serial exposures to demonstrate the retrograde filling of the vertebral artery. Caution must be used in interpretation of films because of artifacts, mechanics of injection and the vasospastic quality of the arteries.[13,14] These may combine to produce a false subclavian steal in





Subclavian Steal Syndrome — From top left: (A.) Retrograde femoral aortogram showing early filling of the innominate artery and its branches. No dye can be seen in the left subclavian artery. (B.) Later film shows outline of the innominate artery, right vertebral artery and left common carotid. The left vertebral artery cannot be visualized at this stage, but a small amount of dye can be seen in the left subclavian artery. An obstructive lesion can be seen in the proximal subclavian artery. (C.) Still later, dye fills the left vertebral artery in a retrograde fashion.

some instances. Rarely, this disease clinically may be confused with the thoracic outlet syndromes, but these may be ruled out by arteriography.

Treatment

Treatment of this syndrome is surgical. DeBakey believes that surgery is indicated if at least 60% of the subclavian artery is occluded on radiographic examination and the blood pressure difference between both arms is more than 30 mm. Hg.[15]

The methods illustrated in Figure 1 have been successfully employed in the treatment of subclavian steal syndrome. The method of ligating the vertebral artery has the virtue of simplicity, but has the obvious disadvantage of providing for no increase in the blood supply to the arm. The bypass methods, whereby a dacron or vein graft is used to shunt blood distal to the obstruction, have been used. The preferred method is the aortosubclavian shunt, because when blood is shunted from the internal carotid, the effective blood supply to the brain is decreased significantly.[11] The aortosubclavian shunt method and the thromboendarterectomy method are probably the most commonly used. The method of choice should depend on the pathology, the condition of the patient and the preference of the surgeon.

The most commonly used incision, when the left subclavian artery is involved, is the left posterolateral thoracotomy with the incision being made through the fourth intercostal space. When dealing with lesions of the right side, a neck incision with the removal of the medial two-thirds of the right clavicle gives good exposure. Generally, a median sternotomy is not necessary, but is preferred by some surgeons.

Prognosis

Immediately following the operation most patients note improvement in their symptoms, quite frequently complete relief. The mortality is low; Javid et al[17] reported a series of 44 patients surgically treated for subclavian steal syn-

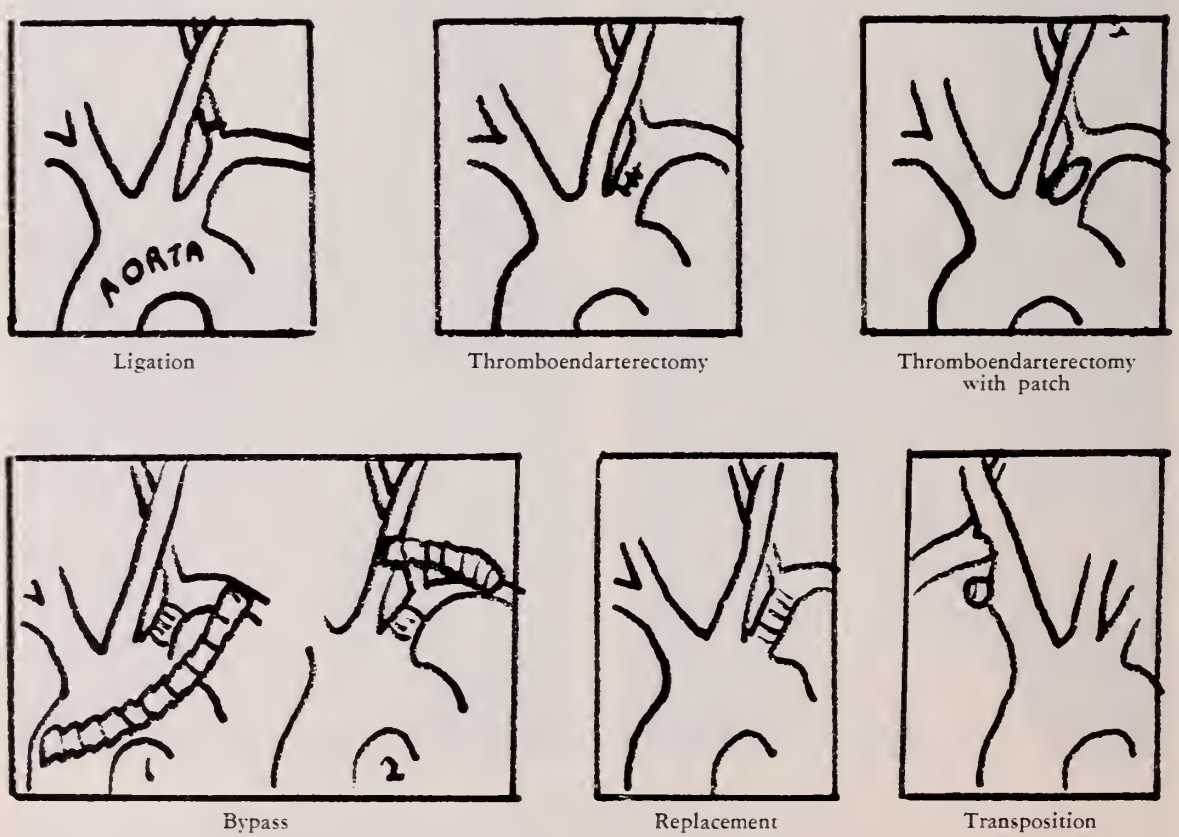


Fig. 1. — Surgical methods successfully used to treat subclavian steal syndrome.

drome, with total correction of the responsible lesion in 42 patients. Killen et al[3] reported that successful revascularization of the subclavian artery uniformly resulted in cure of the symptoms of arterial insufficiency of the arm. In their series of 52 patients, successful revascularization was accomplished in 49. Of 41 cases that had neurologic complaints, cure was obtained in 38.

Summary

Six cases of radiographically-demonstrated subclavian steal syndrome are summarized, with one case presented in detail. With the exception of the fact that five of the six patients reported upon are female, the series appears to be similar to other series reported. A discussion of the etiology, clinical findings, diagnosis, treatment and prognosis of the syndrome is presented.

References

1. Contorni, L.: Il Circolo Collaterale Vertebro-Vertebrale Nella Obliteralzione del Arteria Subclavia alla sua Origine, Minerva Chir. 15:268-271, 1960.
2. Reivich, M. et al: Reversal of Blood Flow Through the Vertebral Artery and its Effect on Cerebral Circulation, New England J. Med. 265:878-885, 1961.
3. Killen, D. A. et al: The Subclavian Steal Syndrome, J. Thoracic Cardiov. Surg. 51:539-560, 1966.
4. Rojas, R. H.; Levitsky, S., and Stansel, H. C. Jr.: Acute Traumatic Subclavian Steal Syndrome, J. Thoracic & Cardiov. Surg. 51:113-115, 1966.
5. Dardik, H. et al: Subclavian Steal Syndrome Secondary to Embolism, Ann. Surg. 164:171-174, 1966.
6. Massumi, R. A.: The Congenital Variety of the Subclavian Steal Syndrome, Circulation 28:1149, 1963.
7. Folger, G. Jr. and Shah, K. P.: Subclavian Steal in Patients with Blalock-Taussig Anastomosis, Circulation 31:241-248, 1965.
8. Coder, D. M. et al: Symptomatic Bilateral Subclavian Steal, Mayo Clin. Proc. 40:473-476, 1965.
9. Santschii, D. R. et al: The Subclavian Steal Syndrome, Clinical and Angiographic Considerations in 74 Cases in Adults, J. Thoracic & Cardiov. Surg. 51:103-112, 1966.
10. Cameron, D. T. and Wright, I. J.: Subclavian Steal Syndrome with Olfactory Hallucinations, Ann. Int. Med. 61:128-133, 1964.
11. Lee, R. H.; Kieraldo, J. H., and Jamplis, R. W.: Surgical Treatment of the Subclavian Steal Syndrome, Am. J. Surg. 114:308-313, 1967.
12. Nemir, P. Jr.; Bahabozorgui, S., and Wagner, D. E.: Brachial-Basilar Insufficiency and the Subclavian Steal Syndrome, J. Thoracic & Cardiov. Surg. 50:534-544, 1965.
13. Marshall. R. J. and Martini, E. L.: Dynamics of the Collateral Circulation in Patients With Subclavian Steal, Circulation 31:249-254, 1965.
14. Pineda, A. and Smith, J. L.: True and False Subclavian Steal Syndromes, Arch. Surg. 92:258-265, 1966.
15. Crawford, E. S. et al: Hemodynamic Alterations in Patients With Cerebral Arterial Insufficiency Before and After Operation, Surgery 48:76-94, 1960.
16. Javid, H. et al: Management of Cerebral Arterial Insufficiency Caused by Reversal of Flow, Arch. Surg. 90:634-643.

▶Dr. Arey, Orange Memorial Hospital, Orlando 32802.

editorial comment

FRANCIS N. COOKE, M.D.

I congratulate Dr. Arey for an excellent article on the "Subclavian Steal Syndrome."

As the author has pointed out in this article, good arteriograms are essential in establishing the diagnosis of vertebral artery flow reversal. Serial x-rays with the rapid change cassette reveal opacification of the affected vertebral artery late in the series after most of the radio opaque media has disappeared from inflow arteries.

The decision as to the type of operative procedure used to overcome the cerebrobasilar insufficiency due to vertebral artery flow reversal must, of necessity, be made at the time of operation. Ideally, normal or near normal blood flow should be established through the brachial artery as well as the vertebral artery, if possible. In my personal experiences, endarterectomy most frequently has been used. Aorta to subclavian bypass grafts will, of course, also produce excellent results. Ligation of the vertebral artery will eliminate the reversal of flow and will be effective for the basilar circulation but will not help the poor function of the arm. Bypass graft from common carotid to subclavian, in my opinion, is a dangerous procedure and I have seen serious consequences develop as a result of syphoning blood from the carotid system.

I again want to congratulate Dr. Arey and thank him for bringing this important syndrome to the attention of the members of the Florida Medical Association.

▶Dr. Cooke, 430 Ingraham Building, Miami 33132.

Self-Evaluation of Post-Hospital Adjustment By 131 Discharged Psychiatric Patients

William C. Ruffin Jr., M.D., Sidney B. Denman, Ph.D.
and Barbara Guyon, B.A.

A relatively large number of people invest their time, talent and training in the care of psychiatric patients referred by physicians for extended treatment in both public and private psychiatric hospitals. It is only natural that referring physicians would have an interest in the effectiveness of the therapeutic efforts of the treatment hospital. To provide such information, an effort was made to obtain an evaluation of post-hospital adjustment from 184 patients who were treated in the psychiatric inpatient unit of the University of Florida Teaching Hospital between Jan. 1, 1965 and Dec. 31, 1966. This figure does not include 73 patients who remained in the psychiatric unit for less than three weeks. Patients who were in the hospital for this short period of time usually did not get involved fully in the treatment program. Most of these patients were admitted to this unit for only psychiatric evaluation, emergency temporary care or were merely awaiting transfer to other psychiatric treatment facilities.

It is hoped that this effort to learn about the reported level of post-hospital adjustment of these patients will provide additional information which may be of use to physicians and hospitals in the future treatment of other psychiatric patients.

Data Sources

Information on each patient's age, sex, financial status, source of medical referral, diagnosis and length of hospitalization was obtained from hospital records and is complete for all cases. Data on the reported level of post-hospital adjustment of these patients were obtained from a questionnaire which was sent to all of the patients who participated in the treatment program and who were discharged during this two-year period.

A word of caution must be provided here because the basic source of data on post-hospital adjustment was a questionnaire in which each patient gave a self-report of his or her present level of adjustment. Such a source of data obviously is open to the entire range of possible errors which subjective rating instruments and self-reports contain. In view of this, all that can be reported is what these patients said to be their level of post-hospital functioning. Ideally, it would have been desirable to have a report from the referring physician to whom each discharged patient was returned or to have a team consisting of a psychiatrist, a clinical psychologist and a psychiatric social worker to evaluate the level of post-hospital adjustment of these patients in their own communities. This was impossible due to the financial limitations of this present study.

At the time the questionnaire was sent, these patients had been discharged from the hospital for a time ranging from 3 to 21 months. Of the 184 questionnaires sent, 139 responses were received. In the total responding group there were two reported suicides, four deaths and two patients who did not complete the questionnaire because they did not regard themselves as having been psychiatric patients. This gave a net total of 131 completed questionnaires or 71% of the 184 patients from whom post-hospital adjustment information was sought.

Characteristics of the Patient Population

The group of discharged psychiatric patients studied contained approximately 60% women and 40% men. The ages of these patients ranged from 13 to 72 years, with an average of 38 years and a standard deviation of 15 years.

Approximately 45% of the patients were referred to this hospital by psychiatrists and 55% were referred by nonpsychiatric physicians. About 96% of the patients were from Florida and 4% were from other states.

From the Department of Psychiatry, University of Florida College of Medicine, Gainesville.

The average length of hospitalization was found to be 92 days, with a standard deviation of 52 days. This group tended to be comprised primarily of middle and upper class white patients. The social class and racial composition arises primarily from the relatively high cost of hospitalization (approximately $1,200 per month) in this psychiatric unit.

The primary diagnosis of the patients in this study covered most of the various types of psychiatric disorders: 46% were diagnosed as psychoneurotic, 31% as psychotic, 15% as personality or character disorders, 6% as transient situational disorders, 1% as psychophysiologic disorders and 1% as organic brain disorders.

All of the patients were treated in a psychiatric facility which attempted to provide a milieu or environment which was conducive to the unlearning of maladaptive thoughts, affects and behavior and the learning of more effective patterns. Treatment was provided by a team of psychiatrists, psychiatric nurses, clinical psychologists, social workers, occupational therapists, a chaplain and other members of the hospital staff.

Level of Post-Hospital Adjustment

In an effort to learn about the patients' evaluation of their post-hospital level of functioning in terms of personal adjustment, they were asked: "As compared with the three months before being in this hospital, how would you rate your personal adjustment during the past three months?" Approximately 84% said that they were either "very much better" or "somewhat better," 14% said that they were "about the same," "somewhat worse," or "very much worse" and 2% did not answer the question.

When asked, "In your employment, school work or household duties, how well have you been working during the past three months as compared with the three months prior to entering this hospital?", 72% said that they were working "very much better" or "somewhat better" than before, 25% said that they were working "about as well," "not working quite as well" or "not working nearly as well" as before, and 3% did not answer the question.

When asked, "As compared with the three months before this hospitalization, how have your personal relations with your family been during the past three months?", 68% said that their family relationships were "very much better" or "somewhat better" than before hospitalization, 29% said that they were "about the same," "somewhat worse" or "very much worse" and 3% did not answer the question.

When asked, "As compared with other people in your community, how well adjusted do you see yourself as being now?", 29% said that they were "very much better adjusted" or "somewhat better adjusted" than most people, 43% said that they were "about as well adjusted" as most people, 24% said that they were "somewhat less adjusted" or "very much less adjusted" than most people and 4% did not answer the question.

When asked, "To what extent do you think that psychiatric hospitalization helped you?", 89% said "very much" or "some," 9% said that "it did not help or hurt," "it made things somewhat worse" or "it made things very much worse" and 2% did not answer the question.

When asked, "Are you now participating in outpatient psychiatric treatment?", 37% of these discharged patients said that they were still involved in either individual or group psychotherapy at the time the questionnaire was returned, 62% said they were not and 1% did not answer the question.

Summary

An examination of the responses which these discharged psychiatric patients made to this questionnaire indicates that the great majority of them said that they were performing at a level that was significantly higher than their level of functioning three months prior to this hospitalization. They reported themselves as improved in personal adjustment, work capability and personal relations with their families. They also reported that they felt that psychiatric hospitalization helped them to achieve a level of adjustment which was reasonably in line with that of other people in their communities. Only about one-third of them were finding it necessary to continue outpatient treatment.

It is hoped that this exploratory study of reported post-hospital adjustment can be extended through the use of more adequate forms of evaluation in future research to provide additional information which might contribute to continually improving current methods of psychiatric treatment.

▶ Dr. Ruffin, J. Hillis Miller Health Center, Gainesville 32601.

Multiphasic Screening — Report of a Demonstration Project in Florida

Joseph E. Frydman, M.D., James E. Fulghum, M.D., Joel S. Glaser, M.D. and Francis R. Meyers, M.D.

Multiphasic screening programs are designed to detect chronic diseases at an early stage, to direct suspects to physicians for definitive diagnosis and treatment, and to provide a procedure for follow-up and statistical analysis. Mass population screening is especially relevant in the detection of diabetes, heart disease, chronic glaucoma, hypertension, tuberculosis and cancer.

While many screening programs are conducted on an intermittent or temporary basis, the advantage of continuous service is obvious.[1-5] On-going screening ranges from the automated multiphasic method utilized by the Kaiser Foundation Health Plan[4] to continuous facilities located in hospitals or sponsored by local health departments.

The need for screening programs is clearly evident, and a careful study conducted in the Southeast (including Florida) indicated that each person over 25 years of age has 1.5 chronic diseases.[6] Adult onset diabetes mellitus, for example, is commonly asymptomatic and discovered only by postprandial blood sugar determination either in the physician's office or in a screening program. The Florida State Board of Health estimates that there are about 110,000 diabetics in Florida and approximately 55,000 of these are undiagnosed.[7] Only a relatively small number of new cases are reported each year. Similarly, studies in Florida have indicated that 2.7 per cent of persons screened for ocular tension required further diagnostic evaluation.

Two multiphasic screening programs including tests for blood glucose and ocular pressure were conducted in Charlotte County, Florida. The purpose of this report is to describe the mechanics of these screening programs and the results.

From the Prevention of Blindness Program, Bureau of Adult Health and Chronic Diseases, Florida State Board of Health, Jacksonville. Dr. Glaser is associate program director and Dr. Frydman is former associate program director. Dr. Fulghum is Bureau director. Dr. Meyers is director, Charlotte County Health Department, Punta Gorda.

Methods and Materials

Through the cooperation of the Charlotte County Medical Society, the Charlotte County Health Department and the Florida State Board of Health, a multiphasic screening program first conducted as a demonstration project in 1964 was repeated in 1966 at the request of local officials. Publicity for the screening program was furnished by local news media and invitations were distributed to homes by school children and food stores. Ministers included pertinent information in announcements to their congregations and a loudspeaker truck was employed in several neighborhoods.

With appointments made by the county health department, the clinic was held Monday through Friday, 2 p.m. to 7 p.m., in a hall provided by the local American Legion Post. Public health nurses and volunteers performed the actual screening procedures under the supervision of physicians. An average of 75 persons were screened per hour.

The following procedures were performed and referral criteria applied: 1) Modified medical history (to exclude procedures already concluded by private physicians)—referred for any reported abnormality not already under physician's care; 2) Obesity—a weight 25 per cent over the individual's accepted standard for age and height*; 3) Blood pressure—a systolic reading of 160 mm. Hg or greater, or diastolic reading of 100 mm. Hg or greater; 4) Ocular pressure—a scale reading (Schiotz tonometer of 5.0 units or less (7.5 gm. weight); 5) Visual acuity—unable to read 20/40 line (Snellen chart) with each eye; 6) Blood glucose—a. 180 mg.% or greater one hour postprandial, b. 150 mg. % or greater 2 hours postprandial, c. 130 mg.% or greater beyond 3 hours, d. 50 mg. % or less between one-half to 2 hours postprandial; 7) chest x-ray any suspicious abnormality.

*Actuarial tables, Metropolitan Life Insurance Company

These referral critera were based on recommendations of the Florida State Board of Health and approved by the Charlotte County Medical Society. Blood glucose was determined by the Unopette (Autoanalyzer Micro-Method 3).

Analysis of Results

A total of 3,720 individuals were screened, 2,148 (58 per cent) women and 1,572 (42 per cent) men (table 1). The majority were in the 55-74 years age group and, although the screening was limited to 35 years old and up, 11 individuals under 35 years were tested. Obesity accounted for 27.7 per cent of the abnormalities (table 2). About one in six persons screened could not read 20 40 with each eye (17.6 per cent) or had elevated blood pressure (16.1 per cent). Eighty x-rays were considered abnormal (2.2 per cent) and were followed.

Of the 92 persons referred (2.5 per cent) for elevated intraocular tension, 21 were diagnosed glaucomatous, an incidence of 0.56 per cent in the total population screened. Another 16 cases were considered borderline (0.43 per cent).

Referrals for abnormal glucose levels (see criteria above) numbered 226 (6.1 per cent). Of this group, 53 were found to have diabetes (1.42 per cent of total screened), 72 did not have the disease, and 32 persons (14.2 per cent of those referred) were known diabetics (this fact was not disclosed despite careful medical history-taking).

Table 1.—Persons Screened

Age	Male	Female	Total
Under 35	1	10	11
35-44	91	193	284
45-54	154	321	475
55-64	339	773	1112
65-74	817	746	1563
75-84	153	90	243
85+	17	15	32
Total	1,572 (42%)	2,148 (58%)	3,720

Table 2.—Abnormalities Found by Disease Category (3,720 persons screened)

	Number	Per cent
Visual Acuity	654	17.6
Glaucoma	92	2.5
Diabetes	226	6.1
Hypertension	600	16.1
Obesity	1,030	27.7
X-ray	80	2.2
Total abnormalities found	2,682	

Discussion

Screening is the presumptive identification of unrecognized disease by tests that can be performed reliably, rapidly and inexpensively on a large number of persons. These tests, while not diagnostic, do identify individuals who should consult physicians for further examination and diagnosis. While the principal goal of screening is case-finding, other objectives are accomplished. Screening programs serve to educate a portion of the population by creating an awareness of disease and health maintenance problems.

The results of this detection program indicate a high incidence of abnormalities with far-reaching implications. The 654 people unable to read the 20/40 line on the Snellen Chart are one example. A similar group of 600 individuals was found to have previously unknown hypertension, and better than one in every four persons screened was overweight by 25 per cent or greater.

The incidence of glaucoma and borderline glaucoma was found to be smaller in this screening program than in comparable studies.[5,9,10] The reason for this decreased prevalence is not readily apparent even by analysis of age distribution.

The Unopette microanalysis method for blood glucose was used for the first time in a mass screening program by the Florida State Board of Health. Using finger tip capillary blood, it was found to be a rapid and convenient technique. Of the 157 persons who were subsequently examined, 85 were found to have diabetes.

Summary

This report presents the organization and results of a multiphasic screening program conducted in 1964 and repeated in 1966 in Charlotte County. Of the 3,720 persons screened, 79.3 per cent were 55 years of age and older, 27.7 per cent were overweight, 17.6 per cent had decreased visual acuity and 16.1 per cent had elevated blood pressure. Abnormal blood glucose levels were found in 6.1 per cent and increased intraocular tension in 2.5 per cent. Suspicious chest x-rays were found in 2.2 per cent.

Acknowledgement

Statistical information was provided by Ralph Gray, David Wolfe and George Bergstrom of the Florida State Board of Health.

References are available upon request from the authors.

Dr. Fulghum, P.O. Box 210, Jacksonville 32201.

Surgical Relief of Intractable Pain Due to Cancer

Irwin Perlmutter, M.D. and David Fairman, M.D.

The problem of pain due to malignancy is very complex and in order to formulate a surgical therapeutic approach to the pain itself, certain prerequisites are essential: (1) The tumor must be surgically irremovable. (2) The efficacy of the application of radio and/or chemotherapy must be considered, but a fairly definite and limited period of time must be allotted as a therapeutic trial in the treatment of both the neoplasm and the pain so that prompt consideration can be given to pain relieving procedures. (3) The pain must be produced by the neoplasm and by no other cause.

Pain from cancer generally appears at a relatively late stage of the disease, but in some patients cancer makes its clinical debut with the pain syndrome. Early, when the tumor is confined to the breast, prostate or gastrointestinal tract, it is rare for pain to be a troublesome feature, but when the tumor invades the abdominal wall, thoracic wall, periosteum or the brachial or lumbosacral plexus, pain becomes a major problem.

Patients can thus be classified into two groups, one in which the disease has followed a progressive course and only after a certain time does pain appear as the prominent symptom, and the other in which the diagnosis of the disease is made when the cause of the pain syndrome is investigated. Although in both groups pain generally implies the propagation of the tumor and the impossibility of its surgical extirpation, a complete evaluation of the possibility of the surgical, x-ray and chemical treatment of the tumor must be carried out before discussing the neurosurgical treatment of pain which always implies symptomatic or palliative surgery. The concept of palliative surgery is relevant because it has been demonstrated by Leriche[1] that the pain syndrome itself is a process involving disturbance of organic function. Constant pain produced by compression of nervous plexuses due to a neoplastic invasion acts pathologically on vital organs such as the cardiocirculatory apparatus and the renal apparatus. It produces gastrointestinal disturbances, cardiac arrhythmias and hypertension. Consequently, pain alone may initiate and/or perpetuate a vicious and destructive biological cycle. Suppression of pain not only eliminates the patient's suffering but also improves his general condition, contributes to his better nutrition and, therefore, may even permit the application of other therapeutic modalities, such as chemotherapy or radiotherapy, which previously had been contraindicated. This is an important reason for performing pain relieving procedures early in the course of the disease.

Current Concepts

Pain of cancer is usually treated first with symptomatic medication selected from among the host of current analgesic drugs, most of which are ineffective. Because of this the patient is then given morphine, which becomes ineffective because addiction, with its psychopathologic symptomatology, soon follows. It is well known that despite progressive increases of morphine dosage, shortening of the sedation period occurs, increasing the patient's suffering and anxiety.

Favorable results in the application of analgesic therapeutic "cocktails" including psycholeptics, tranquilizers, analgesic drugs and so forth,

have been reported but unfortunately their relative and transitory effects become evident. Pain in cancer usually is treated medically and by radiotherapy and chemotherapy; only when every other possibility has been exhausted or discarded is the neurosurgeon consulted.

Pain Relieving Procedures

The neurosurgical procedure selected to relieve pain resulting from cancer depends upon the origin of the pain and the knowledge of the neuropathways from that area to consciousness.

In the treatment of the pain of certain malignant neoplasms about the face and neck, section of the roots of the fifth and ninth cranial nerves, as well as of certain of the cervical nerves, is helpful and efficient.

In the dorsal region, to perform a satisfactory pain relieving rhizotomy, a large number of roots must be sectioned, incurring the risk of disturbing the circulation of the spinal cord.

A widely used pain-relieving procedure is cordotomy, usually performed at either the upper thoracic or upper cervical level. The cord is rotated after section of the dentate ligament and an incision is made to a depth of at least 5 mm. in the anterior quadrant. The risk of morbidity and mortality with laminectomy and cordotomy must be considered because many of the cancer patients are cachectic and may develop unexpected complications. More recently, percutaneous cordotomy, performed using local anesthesia and under x-ray control, and interrupting the spinothalamic tract by the use of a radio frequency current has been heralded as a relatively innocuous and yet effective pain relieving procedure. This method is quite accurate and eliminates the surgical risk of open laminectomy.

Incisions into the pain pathways at the medullary and mesencephalic level have been performed, but exposure and sectioning of the tract in the midbrain has carried an excessive mortality and a high incidence of sensory disturbance, such as paraesthesia, which is far more upsetting to the patient than the original pain.

Lobotomy, consisting of bilateral transection of areas of the frontal lobe, has been widely used. A lobotomized patient is not relieved of his pain but is relieved of some of its psychic aspects. He still has pain but it doesn't bother him. This procedure, because of complicating personality defects which frequently result, now is reserved for only a special category of patients.

Satisfactory relief of intractable pain has been obtained with the application of stereotactic surgery to ablate selective thalamic areas. The stereotactic technique is concerned with the use of local anesthesia, a small scalp incision and burrhole to direct an electrode to a target point in the thalamus with a minimum of disturbance and neurological complication. It avoids many of the hazards of open surgery and has been demonstrated to be an efficient method with a minimum of side effects.

Summary

The physician caring for a patient with intractable pain due to cancer has a very difficult problem. The patient must be conditioned to the idea of a palliative operation if he is not to be completely demoralized. A realistic approach should be made and the advantages of the operation to relieve pain should be stressed rather than stressing the negative aspects of loss of control of the disease.

Relief of pain, especially the unremitting, demoralizing pain of malignant tumors, is extremely worthwhile, especially if it can be gained without serious complication. Modern neurosurgical procedures such as trigeminal rhyzotomy, percutaneous cordotomy and stereotactic thalamic tractotomy can in many instances be of help in relieving intractable pain due to cancer and should be performed as early as possible once it is understood that the neoplasm cannot be surgically removed and that it, and it alone, is the cause of the pain.

References

1. Leriche, T.: Pain Surgery, Morata Ed., Madrid, 1942.
2. Lewis, T.: Pain, New York, The Macmillan Company, 1947.
3. White, J. C., and Sweet, W. H.: Pain, Its Mechanisms and Neurosurgical Control, Springfield, Ill., Charles C. Thomas, 1955.
4. Lin, P. M.; Gildenberg, D. L., and Polavoff, D. P.: An Anterior Approach to Percutaneous Lower Cervical Cordotomy, J. Neurosurg. 25:553-560, 1966.
5. Mullan, S. et al.: Percutaneous Interruption of Spinal Pain Tracts by Means of a Strontium Needle, J. Neurosurg. 20:931-939, 1963.
6. Rosomoff, H. L.; Brown, C. J., and Sheptak, P..: Percutaneous Radiofrequency Cervical Cordotomy: Technique, J. Neurosurg. 23:639-644 (Dec.) 1965.
7. Spiegel, E. A., and Wycis, H. T.: Long Range Results In the Treatment of Intractable Pain by Stereotactic Midbrain Surgery, J. Neurosurg. 19:101, 1962.
8. Fairman, D.: Evolution of Psychosurgery Technique, Studies in Lobotomy, Greenblatt, Arnot and Solomon, editors, New York, Grune and Stratton Inc., 1949.
9. Fairman, D., and Perlmutter, I.: Results in Stereotactic Thalamotomy for Treatment of Intractable Pain, 11th International Symposium on Stereoencephalotomy, Vienna, Austria, 1965.
10. Fairman, D.: Thalamic Tractotomy for the Relief of Intractable Pain in Cancer, Ninth International Cancer Congress, Tokyo, Japan, 1966.
11. Fairman, D., and Perlmutter, I.: Unilateral Thalamic Tractotomy for the Relief of Bilateral Pain in Malignant Tumors, 111th International Symposium on Stereoencephalotomy, Madrid, Spain, 1967.

Dr. Perlmutter, 4685 Ponce de Leon Boulevard, Coral Gables 33143.

Cesarean Hysterectomy Experience

A Five Year Study

Donald R. LaPlatney, M.D. and James A. O'Leary, M.D.

A difference of opinion exists in the current obstetric literature regarding the place for cesarean hysterectomy in the management of parturients. Some authors with favorable statistics have recommended the procedure in lieu of tubal ligations.[1,2,5] Other authors cite morbidity and complications that tend to dissuade the use of this procedure except in emergency situations.[4,7]

It seems apparent that the resident in training and the surgeon in practice will need to do elective procedures to develop and maintain the skill required to successfully perform the operation in life threatening situations. It seems equally apparent that the differences in experience of the debating authors probably can be explained, and it is the purpose of this paper to analyze the variation in results obtained in five years (1962-1966) at the Jackson Memorial Hospital, Miami, and to suggest criteria for screening patients for elective cesarean hysterectomy.

Case Material

There were 60 cesarean hysterectomies performed at the Jackson Memorial Hospital during the five-year period, representing an incidence of 0.31% of the total deliveries and 5.4% of the cesarean sections performed during the same period. Nine operations were performed by the attending staff and 51 by the resident staff. No attempt is made to separate the two groups.

The patients ranged in age from 19 to 44 years with an average age of 32.5 years. The average number of children per patient was six while the group included two primiparas and many patients with more than ten children. Forty of the 60 patients had had a previous cesarean section, and the average for this group was 2.2 previous abdominal deliveries. The indications for the original cesarean section in this group is consistent with that usually described. The live infants weights were recorded from 2.7 pounds to 10.2 pounds with an average of 7.9 pounds. There was one set of twins included in the series. Eight infants were stillborn.

The average hospital stay was 10.4 days with a range of 5 to 25 days. The average postoperative hospitalization was 7.4 days.

Methods

Fifty-eight of the 60 patients underwent a total hysterectomy and two patients had a subtotal operation. Evaluation of the pathology reports confirmed the presence of the cervix in 57 of 58 of the total hysterectomies.

Three patients underwent radical hysterectomy and node dissections, two of whom were known to have invasive cancer of the cervix and the third having cancer in situ with a strong suspicion of invasion.

Hysterectomy Indications

The professed indications for surgery are listed in table 1. For statistical analysis these have been reclassified as acute emergencies, indicated elective and elective or sterilizing procedures (table 2). There were 14 emergencies (23%). There were 28 patients in the indicated elective group including six with known positive cytology and two strongly suspicious of cancer (47%). Eighteen patients were considered elective, that is for sterilization (30%).

Results

No deaths were recorded in this series. Morbidity was noted as follows: no temperature elevation for 30 patients (50%); temperature of 100.4 F. for two or more days, 21 patients (35%) and temperature of 102 F. for two or more days, 9 patients (15%). Prophylactic antibiotics were liberally employed in the afebrile group.

The surgeons' operative notes gave additional insight into the results as recorded in Table 2. The difficulty noted with bladder dissection is consistent with other reported series. The one bladder perforation is similarly consistent with other large series of patients.

From the Department of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

Complications

Thirty-eight of the 60 patients suffered a total of 47 serious complications as outlined in Table 2. The patients with urinary tract infections probably had them prior to delivery as there is a large incidence of urinary tract infection in our clinic patients. Similarly, the severely anemic patients had their diagnoses established antepartum. One patient had two postoperative procedures for excessive bleeding. The remaining complications were compatible with those in other reported series.[6]

The two patients with known invasive cancer were reported to have no positive nodes. One patient who had a total hysterectomy was later discovered to have invasive cancer of the cervix, but she signed out of the hospital on her sixth postoperative day and was lost to follow-up. One patient who underwent radical hysterectomy had no residual cancer in the resected uterus.

Despite the recorded difficulty with bladder dissections and the one bladder perforation, there were no fistulae in the 42 of 60 patients available for follow-up.

Transfusion Experience

Fifty-two out of the 60 patients (87%) were transfused. There were no patients transfused prior to surgery who did not require additional blood during or after surgery. Only 11 patients had single unit transfusions. The 52 transfused patients received a total of 208 units of blood for an average of four units each. There were no apparent complications from the transfusions (table 3). The transfusion data can be rearranged when we combine patients who had emergency operations, preoperative cancer and preoperative anemia, who total 22, and who received 145 units or an average of 6.9 units each. That leaves the remaining 30 patients to share a total of 63 units for an average of 2.1 units each. Unfortunately, most authors do not discuss the transfusion experience nor the implications of added risks involved for the patient.

Comment

Careful analysis of the data from these patients suggest that it may be able to predict and therefore reduce the number of patients who will have postoperative complications and the possibility of unusual transfusion requirements (table 3). The patients' age, parity, number of previous cesarean sections, estimated baby weight and preoperative hemogram are particularly important in this series. When the combination of one or more postoperative complications, that is, morbidity, infection and high transfusion risk occur, it is found that 80% of the patients can be expected to have trouble simply because they are above the average age for the series. In addition, 79% may be complicated because they are of above average parity. Likewise, 80% of those who have had more than three cesarean sections will list major complications. Ninety-two per cent of those that had above average weight babies (more than eight pounds) along with 83% of the patients who have preoperative anemia also will suffer major complications.

Table 1.—Professed Operative Indications

Ruptured uterus, acute		5
Ruptured uterus, occult		5
Fibroid uterus		8
Hemorrhage		4
Lacerations	2	
Abruptio	2	
Invasive carcinoma cervix		2
In situ carcinoma of cervix		4
Multiple cesarean sections		16
Systemic disease		4
Hematological	1	
Cardiovascular	1	
Orthopedic	1	
Psychiatric	1	
Rh sensitization		2
Congenital anomaly		1
Endometriosis		1
Sterilization—(no other indication listed)		8

Table 2.—Classification of Indications, Operative Difficulties and Postoperative Complications

Classification of Indications	
Acute emergency	14
Indicated elective	28
Sterilization	18
	60
Operative Difficulties	
Difficult bladder dissection	15
Bladder perforation	1
Excessive hemorrhage	4
Bleeding vaginal cuff	2
	22
Postoperative Complications	
Urinary tract infection	23
Ileus	2
Pneumonia	3
Vault infection	3
Wound infection	1
Hematoma	3
Thrombophlebitis	1
Wound disruption	1
Reoperation for hemorrhage	3
Hepatitis	0
Marked anemia	7
Vesico-vaginal fistula	0
	47

Table 3.—Transfusion Data and Analysis of Risk Factors

Transfusion Data

Single unit transfusion	11 (18.2%)
Patients transfused	52
Percent transfused	87%
Average transfusion (units)	4
Range	1-11
Hepatitis	0

Analysis of Risk Factors

Factors	Percent
Above average age (32.5 years)	80%
Above average parity (6 or more)	79%
Multiple previous cesarean section (3 or more)	80%
Fetal weight 8 lbs. or more	92%
Preoperative anemia	83%

The scarcity of subtotal procedures in this series is a reflection of department policy. The transfusion experience suggests that this procedure may have been employed to the patients' benefit. The comments in the operative notes would tend to contradict the statement in Eastman's text[3] that the total operation is relatively safe and easy to employ.

The absence of maternal mortality is undoubtedly a reflection of the size of this series, as figures from 0.5 to 2.0% have been previously presented.[1,6,7]

Summary

Cesarean hysterectomy experience at the Jackson Memorial Hospital from 1962 to 1966 is presented. Morbidity, complications and transfusion experience attest to the magnitude of risk incurred by candidates for this procedure. The risks associated with the emergency operations are justifiable and must be expected.

Data suggests that elective cesarean hysterectomies can be associated with reduced risk if careful attention is made in selection of patients. High risk is found in the older patients, those who are grand multiparas, patients whose estimated fetal weight is greater than eight pounds, presence of anemia and those women who have had more than three previous cesarean sections.

Attention is directed to the increased incidence of blood transfusions in the risk assessment of cesarean section hysterectomy.

References

1. Alford C.; Miller A., and Simpson, J.: Cesarean Section Hysterectomy, A 10-Year Review, Am. J. Obst. & Gynec. 82:664, 1961.
2. Davis, M.: Complete Cesarean Hysterectomy—A Logical Advance in Modern Obstetric Practice, Am. J. Obst. & Gynec. 62:838, 1951.
3. Eastman, N. and Hellman, L. W.: Obstetrics, New York, Appleton-Century-Crofts, Inc., 1966.
4. O'Leary, J. and Steer, C.: A 10-Year Review of Cesarean Hysterectomy, Am. J. Obst. & Gynec. 90:227-231, 1964.
5. Pletsch T. and Sandberg, E.: Cesarean Hysterectomy for Sterilization, Am. J. Obst. & Gynec. 85:254, 1963.
6. Schneider, G. and Tyrone, C.: Cesarean Total Hysterectomy: Experience With 160 Cases, Southern M. J. 59:927, 1966.
7. Jones D.; Smith, R, and Williams, T.: Cesarean Hysterectomy, Minnesota Med. 51:17, 1968.

▶ Dr. LaPlatney, 20730 North Miami Avenue, Miami 33169.

editorial comment

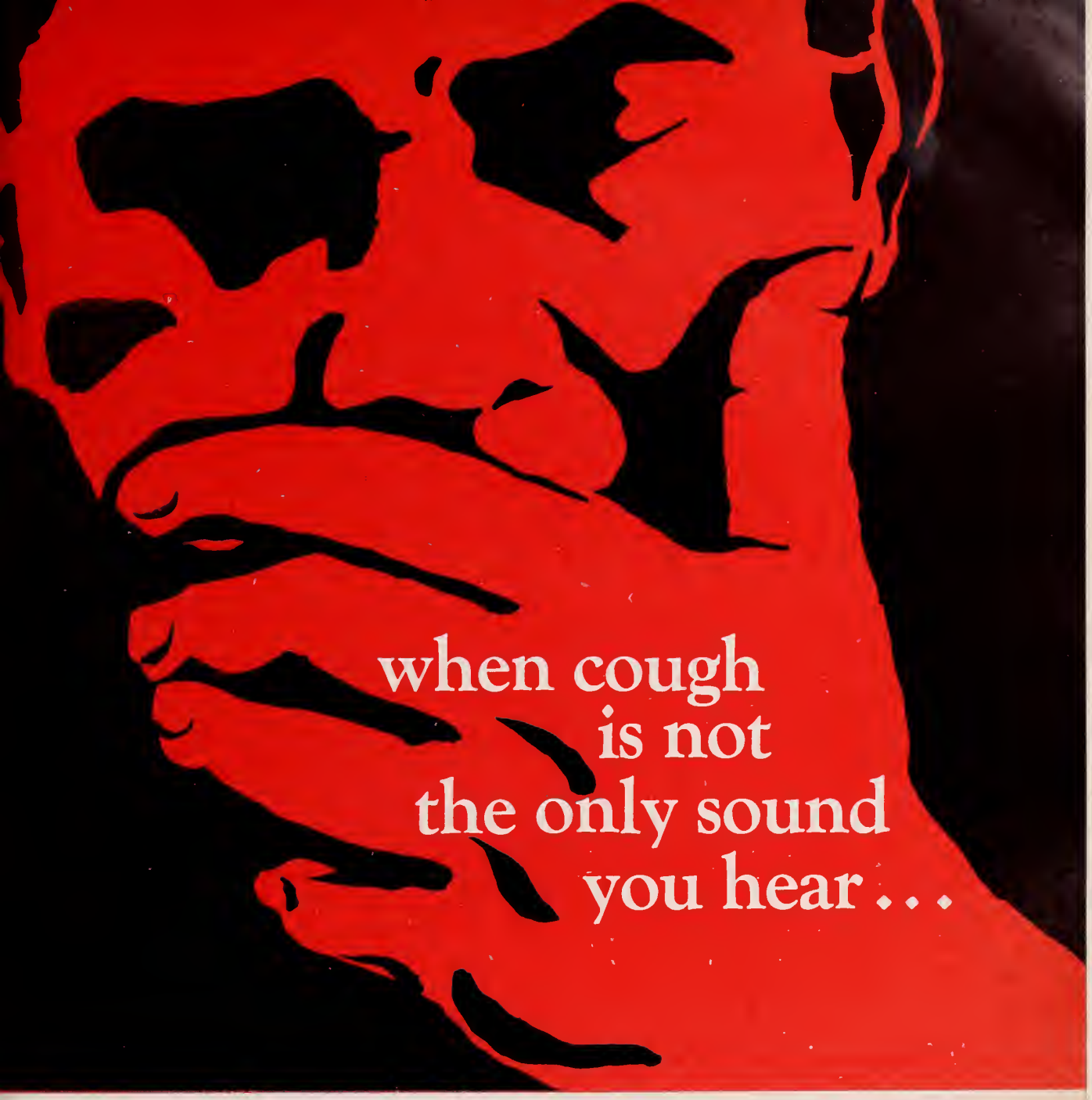
Sam W. Denham, M.D.

This paper offers a refreshingly accurate presentation of cesarean hysterectomy experience. In a teaching program where future specialists in obstetrics and gynecology are trained, it is a necessity that cesarean hysterectomy be a portion of their background and experience. In many instances it is a lifesaving procedure for the mother. Most authorities will agree that with continuing experience with cesarean total hysterectomy, the general safety and desirability of its performance is enhanced. The point is presented, however, that its performance is not recommended to the occasional operator.

If sterilization is the only desired consideration and the mother's condition is markedly compromised, either from preexisting disease or obstetric factors, simple judgment would dictate a tubal ligation in preference to cesarean hysterectomy.

We all should be aware of the increased risk associated with multiple blood transfusions before, during and after this particular procedure. The well-trained obstetrician often can make a judgment that would hold transfusion to a minimum by early recognition of an impending obstetric calamity. This factor, as well as patient selection, does explain variations in the experience of reporting authors.

▶ Dr. Denham, 2700 Riverside Avenue, Jacksonville 32205.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining: enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

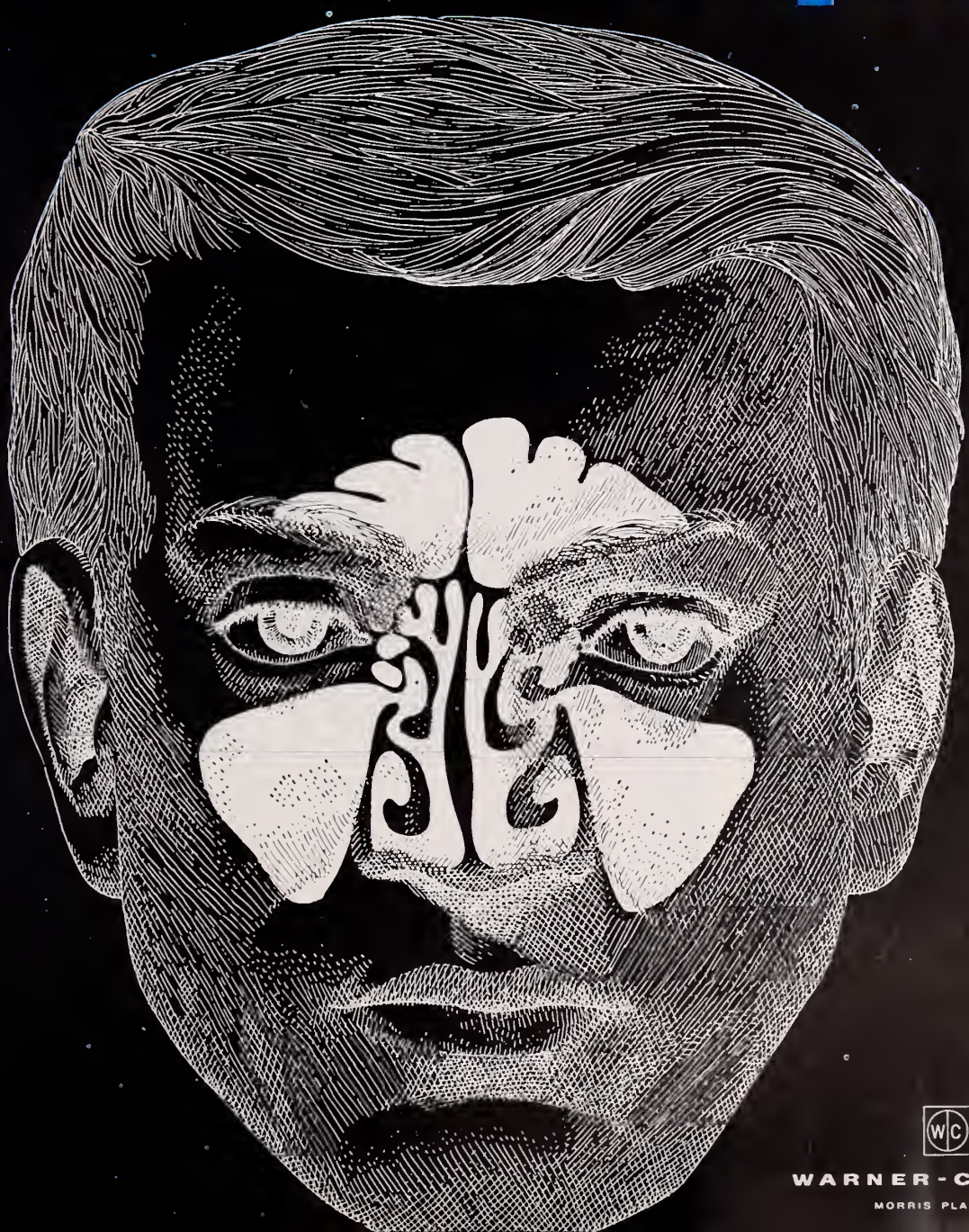
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

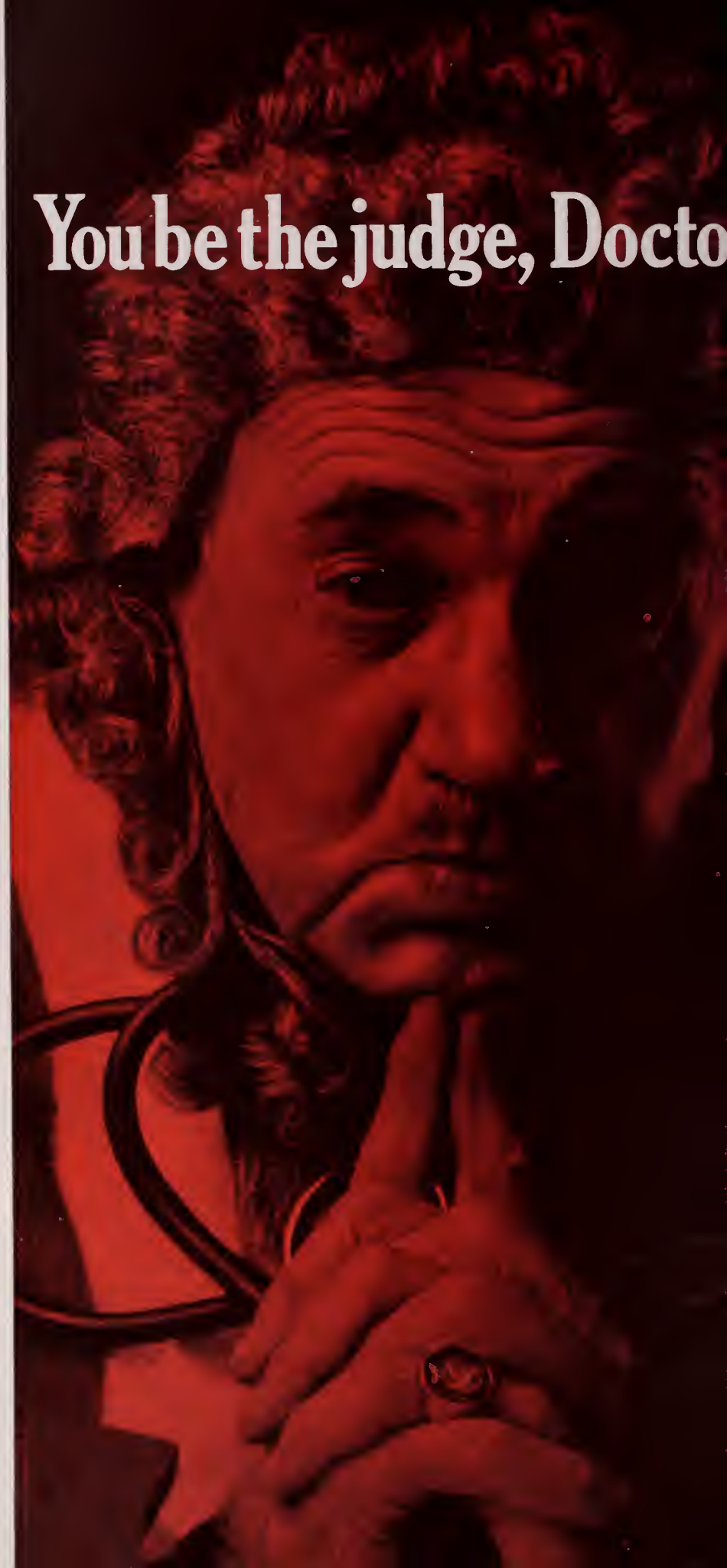
Sinutab | 2 tabs. q.4h.



WC

WARNER-CHILCOTT

MORRIS PLAINS, N.J.



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

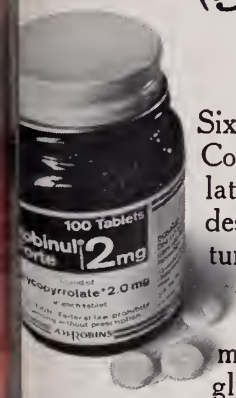
Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information. Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

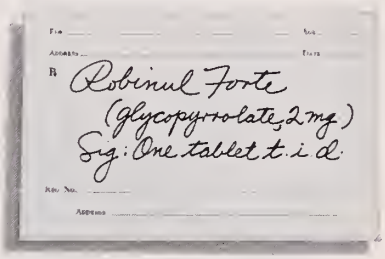
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and a marked inhibitory effect on intestinal tone. We're confident you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Easy on the Budget...
Easy on the Mother

Tablets & Elixir

For Iron Deficiency Anemia

FAMOUS Fergon®
brand of FERROUS GLUCONATE

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016



THE BRADLEY CENTER

An all new homelike psychiatric residence located on a lovely five-acre tract inside the city, providing a comprehensive range of services, including inpatient (28 beds), day care, and outpatient treatment. The therapeutic setting is an open community one with no provisions for locked wards. Each patient participates in an intensive treatment program consisting of individual pyschotherapy, group psychotherapy, topical small group discussions, occupational therapy and recreational therapy, and other group activities in the Center as well as in the community, depending on individual interests and needs. Drugs are used when appropriate.

Any individual may be admitted who, in the opinion of the staff, might benefit from the services provided in this particular setting. This can best be determined by a preadmission consultation with the person and a responsible member of his family.

Brochures and rate schedules are available on request.

Leonard T. Maholick, M. D.
Medical Director

Maj. Gen.(Ret.) Howard Snyder
Administrator

THE BRADLEY CENTER, INC.
2000 Sixteenth Avenue
Columbus, Georgia 31901
Area Code 404 - 324-4882



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

In childhood



Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

diarrheas...



- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. 2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. 3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. 4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine



Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

800486

Florida Medical | editorial

From the Editor

Franz Stewart

Dr. H. K. Moore, writing from Key West, in the summer issue of FLORIDA FAMILY PHYSICIAN, talks about hospital records. He brings out a point which deserves attention. I hope he will forgive us for quoting one sentence from his excellent and provocative editorial. "When educated, intelligent people accept and condone worthless records merely to qualify for accreditation of a hospital, who is fooling whom?"

No one doubts the need of a careful, thoughtful history and physical for good patient care, now and for reference later. No one doubts the benefits that have accrued from national hospital accreditation groups who have raised standards and helped classify hospitals.

The very best records often cover long periods of patient care, with episodes of hospitalization, not complete entities within themselves. The real history is in the physician's file and not a part of the hospital record at the time of each admission. The complete hospital record becomes duplication, and is needed only to give the hospital a record for accreditation needs. This is not necessarily bad; it is just true. The hospital usually employs someone to write down a record of a history and physical to meet the needs of the hospital, but this must not be confused with the needs for good patient care.

A house physician who will add to patient care is rarely the person who stamps out record after record, without interest or participation in the care of the patient. A good salary will make him polite and make his coat clean and white but will not solve this problem.

You are right, Dr. Moore, the "payed for" record is a way to fill a need, but is just thin veneer. A good, nonphysician clerk would do a much more valuable job, and leave the house physician a chance to prove his worth in the area of his ability and training. The attending physician must always be responsible for notes which make clear the patient's problems, the procedures done, and the basis of judgments made.

Florida Medical meetings

FMA Approved Postgraduate Meetings

NOVEMBER

1- 2 Athletic Injuries Seminar, J. Hillis Miller Health Center, Gainesville

7- 9 Today's Hospital Problems: Second Annual Conference, University of Florida and Mound Park Hospital Foundation, Tides Hotel and Bath Club, Redington Beach.

15-16 Geriatric Rehabilitation and the Long Term Management of the Patient With a Chronic Disability, Cedars of Lebanon Hospital, Miami

DECEMBER

6- 8 Current Concepts on Management of the Spinal Cord Injured Patient, Americana Hotel, Bal Harbour

9-11 Present Status of Orthotics and Immediate Postsurgical Prosthetic Fitting of the Amputee, Americana Hotel, Bal Harbour

JANUARY

2- 5 Teaching Family Medicine Workshop, University of Miami, Miami

9-12 Sixth Annual Postgraduate Seminar in Anesthesiology, Eden Roc Hotel, Miami Beach

15-18 Seminar in Surgery Art and Science in Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach

15-19 Bedside Interpretation of Laboratory Data, Americana Hotel, Bal Harbour

23-24 Seminar in Obstetrics and Gynecology, J. Hillis Miller Health Center, Gainesville

26-30 Annual Pediatric Postgraduate Course—"Renal and Genitourinary Disorders," Deauville Hotel, Miami Beach

MARCH

Mar. 31-Apr. 2 Current Trends in Chest Roentgenology, Fontainebleau Hotel, Miami Beach

National and Regional Meetings in Florida

NOVEMBER

19-20 Council on Arteriosclerosis, Balmoral Hotel, Bal Harbour

21-26 American Heart Association, Americana Hotel, Bal Harbour

DECEMBER

1- 4 Clinical Convention of the American Medical Association, Miami Beach

4- 6 Academy of Psychosomatic Medicine, Eden Roc Hotel, Miami Beach

9-11 Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton

10-14 American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour

FEBRUARY

13-15 Society of University Surgeons, Fontainebleau Hotel, Miami Beach

MARCH

2- 5 International Anesthesia Research Society, Americana Hotel, Bal Harbour

15-19 American Academy of Allergy, Americana Hotel, Bal Harbour

APRIL

28-May 1 American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour

30-May 3 Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne

MAY

2- 4 American Academy of Psychoanalysis, Deauville Hotel, Bal Harbour

3 American College of Psychiatrists, Deauville Hotel, Bal Harbour

4- 9 American Society for Microbiology, Fontainebleau Hotel, Miami Beach

5- 9 American Psychiatric Association, Americana Hotel, Bal Harbour

22-25 National Tuberculosis and Respiratory Disease Association, Fontainebleau Hotel, Miami Beach

24-26 American Thoracic Society, Fontainebleau Hotel, Miami Beach

Dr. John M. Packard of Pensacola

Jack W. Fleming, M.D.

The medical profession and the people of the state of Florida will lose a very valuable physician and able leader to the neighboring state of Alabama at the end of this year when Dr. John M. Packard of Pensacola will assume a new role in Birmingham. Dr. Packard will become director of the Alabama Regional Medical Program and professor in the Division of Cardiology, Department of Medicine, Medical College of Alabama.

Dr. Packard, in the private practice of cardiology and internal medicine in Pensacola for the past 14 years, has played a leading role in the development of the Pensacola Educational Program, a coordinated effort by the city's physicians and hospitals to provide a continuing medical education and internship-residency program. His leadership in this field will bring valuable experience to his new position. Although Dr. Packard is primarily interested in cardiology, his new responsibilities will extend to projects in all disease categories of the Regional Medical Program.

Dr. Packard had an early exposure to excellence in medicine since his father, Dr. E. N. Packard, an able physician and gentleman, was director of the well known Trudeau Sanitorium in Saranac Lake, New York. John reflects his father's best characteristics. He received his B.A. degree from Yale University in 1942. After receiving his medical degree from Harvard Medical School (AOA) in 1945, he completed an internship at Presbyterian Hospital in New York City followed by a medical residency at Peter Bent Brigham Hospital in Boston. For the following eight years he served in the U.S. Navy. Most of that time was spent at Pensacola's School of Aviation Medicine in the research department of Dr. Ashton Graybiel. There he published a number of research papers. In the latter part of his Navy service, he served as flight surgeon to the Carrier Air Group #7.

Although Dr. Packard has received many high honors and belongs to a long list of honorary and professional organizations, he is most proud of his family. He is married to the former Ann Maurine Schoonover and has seven children. His recreation time is spent with them. He is active in Christ Episcopal Church, serving as lay reader and senior warden.

Dr. Packard is a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians and a Fellow of the American College of Cardiology. He has been a leader in the hospital staffs in Pensacola, serving as president of two hospital staffs. Also, he has been president and chairman of the board of the West Florida Heart Association.

Dr. Packard has made many contributions to medicine on a state level, serving as president of the Florida Society of Internal Medicine in 1964 and first vice president of the Florida Heart Association in 1968, in addition to a number of important committee assignments by these organizations. He has been on the Scientific Work Committee of the Florida Medical Association and been very active in the affairs of this organization. He was a member of the editorial board and assistant editor of the Journal of the Florida Medical Association for nine years.

We wish him well in his new venture and reluctantly give him up to Alabama but congratulate the faculty of the Medical College of Alabama on their good judgment in Dr. Packard's appointment.

▶ Dr. Fleming, 1750 North Palafox Street, Pensacola 32501.

Reminiscences

Robert J. Needles, M.D.

This is in response to the article on malaria by Dr. Fred Butler which appeared in the "Comment" section of the September issue.—Ed.

The reminiscences of Dr. Fred Butler concerning malaria and World War II interested me greatly. When I applied for a commission in the Navy in January 1942 I was advised to mention the fact that I had spent two years on a rubber plantation in the Amazon Valley a few years before, because tropical diseases were then known to present problems of unknown complexity. The Navy did not take me because they said my eyes and teeth were not good enough. They eventually may prove to have been right after all. But the Air Force did take me, and again the application, on advice of an officer on the staff of the surgeon general, was to mention the fact that I had had experience in tropical medicine. Soon after getting into the Air Force I realized the horrible consequences of my indiscretion. Because, you see, whether it was true or not, it was universally believed that one was almost always sent to the area where he was least qualified to function and where he would be certain to have unhappiness, at any rate. Thus, while young medical officers were being sent to the Canal Zone for malaria training, others were going to the Aleutians and Greenland. It was to the latter two areas that I figured I would eventually be sent. Nothing eventuated of it. I went neither to the tropics nor to the arctic areas. I was requisitioned for the 13th Air Force, then stationed on Morotai, but the air surgeon decided I was more valuable where I was.

Dr. Butler's remarks on the failure to see the problem of malaria at first should warn us not to be too confident of anything, because those lessons in regard to malaria and also to yellow fever had been learned at painful cost in the early years of the century when the Madeira Marmore railroad was being built. The tiny railroad was supposed to give Bolivia an outlet to the sea through the Amazon Basin. It failed two or three times of being built until finally something was done about mosquito borne disease. Again, in the Canal Zone, the lesson was learned three or four times over. The Canal could not be built until malaria was brought under some degree of control.

In the Amazon Valley, vivax malaria was not much of a problem. It responded well to a combination of quinine and plasmochin. Recurrences, of course, were common. When men would become drenched or chilled in tropical rains a good many of them would break out with a recurrence of malaria. The falciparum malaria was a different matter. I doubt that I ever saw a case cured. In fact, we had a half dozen Frenchmen who had been variously sent from such places as Indochina and North Africa to the penal colony in French Guiana. Escaping, incredibly, they had ended up on the plantation. They had falciparum malaria of the most stubborn type. We did not, of course, have atabrine. But certainly one could treat them with quinine and plasmochin until hell froze over and you would still find the gametocytes in small numbers in the circulating blood.

Dr. Butler does not mention it, but there was a lot of talk in the Southwest Pacific about atabrine being the cause of male impotence. As a result, I was told the mess halls of the South Pacific were yellow with the dust of atabrine tablets crushed under feet. The same was true of radar, since any isolated units sitting on mountain tops behind these devices were certain that they were or would become inadequate. All in all, it was quite a war. One wonders what we learned from it; or, because we are predatory animals, if we are destined to have one every so often, in which case, let us look to the past for some information as to what we may meet in the future.

▶ Dr. Needles, 615 Eleventh Street North, St. Petersburg 33705.

Physician Participation in Good Government

William B. Welch, M.D.

Dr. Welch attended both the Republican and Democratic Conventions and presented a report to Journal readers which appeared as a feature article in the October issue. The following article represents some further thoughts gleaned from his experiences.—Ed.

It was my pleasure during the recent Republican and Democratic conventions to discuss the role of physicians in politics with Congressman Durward G. Hall, M.D. and Congressman Thomas E. Morgan, M.D.

Dr. Hall is a general surgeon who has been serving in Congress for eight years from the seventh district of Missouri. He is a Republican.

Dr. Morgan is from Fredericktown, Pennsylvania, and has been in the private practice of medicine there since 1934. He is a Democrat and has served in Congress since 1944. At present he is chairman of the House Foreign Affairs Committee.

Both men think there is a great lack of participation in local, state and federal political action on the part of the private practitioner of medicine.

Dr. Hall believes the true definition of a politician is an individual chosen by the electorate to represent the people in the choice for the best form of governmental legislation. Such individuals, in his opinion, must have a high degree of education and must demonstrate abilities and skills in: 1. Organization of voluminous information; 2. Dealing with persons of various backgrounds over long periods of time; 3. Making proper decisions in times of crises, and 4. Having a knack for keeping their fingers on the pulse of the people.

Both men feel that if you couple these prerequisites with the participation in government you have the art of political science. They believe that this nation is now at a time when the republic needs more collective rather than individual action by physicians. It is their belief that this nation, from its past experience, can no longer afford to be represented by men who use substitute measures of expedience, vacuum-filling legislation and outright sell-outs to organized privileged groups as an attempt to deliver good government to the people.

"It is time for all statesmen to believe and demonstrate their belief in responsible progress," Dr. Hall stated. "Many physicians signed the Declaration of Independence," he reminds us. The present need for physician participation is greater than at any other time in our past, because of the present crises. "Everyone knows the harm 'good folks' do by standing idly by," said Dr. Hall. In his opinion, such lassitude has brought on socialistic trends in modern government. He is convinced that physicians must continue to work for responsible, cautious progress within their parties or groups, even though their sponsored legislation meets multiple failures in legislative committees.

Both men felt that many more physicians must help obtain responsible legislation by becoming active candidates themselves. Patients will hate to lose them as their doctors, but they will rally to their support because of their recognized multiple abilities. For those of you who cannot be candidates, these men suggest that you should use your organizational ability by actively participating at the block or precinct level and in the political action groups of your choice.

Both congressmen recognize that financial aid is always a necessity and by the use of shoeleather and perspiration one can keep necessary financial assistance within economic reason.

Dr. Hall suggested organizing a "Helping Arts" or "Para-Medical Committee" for all candidates for better government. He has done this in his own district in Missouri. They meet monthly to support and agree on all resolutions to the individual congressmen, helping them to meet the burden of representation, which he hastily admits is a two-way street (meaning they are elected to represent all registered voters, both Democrats and Republicans). Specifically, they should participate in health legislative programs and encour-

age local and regional medical societies to support these programs. Physicians should volunteer for or at least serve on, when requested, appointive positions in the various governmental commissions. If this is not done, these positions will continue to be filled totally by social workers, academic M.D.'s, administrators and lawyers who do take time to participate to make their views heard.

Dr. Morgan suggests that the private practicing physicians are guilty of a worse offense than any avaricious, opportunistic politician, because while physicians are qualified leaders, they seldom participate in any form of political action.

Dr. Hall thinks that the two great immediate issues that deserve an expression of opinion by physicians to their own senators and congressmen as well as to their local and state legislative representatives are:

1. Wilbur Cohen's (Secretary of Health, Education, and Welfare) attempt to form a Federal Health Council which would preside over and be the only contact with the President regarding medical information, education and the suggested enactment of legislation.

2. A minimum guaranteed annual income plan for all people, regardless of their qualifications and circumstances.

Dr. Hall reminds us that the most cardinal sin, according to St. Luke, is the "sin of omission." He admonishes us not to be guilty of idle observation while the human ovens of greed are being stoked.

From my lengthy interviews with the majority of physician delegates in both parties and with these congressmen, it would seem that they are suggesting that if we truly desire to remain the leaders of cautious progressivism we must form not only our own state political action committee but our own such local groups. These must include all the allied health professions. This activity should be carried out not only during election years but on a continuing basis. Our interest must be not only in federal representation but in representative state and local government. The environment we seek for our patient-doctor relationship will be only as good as our ability to constantly and adequately express ourselves to these men who have sacrificed themselves to represent us.

The present election is upon us. Regardless of what our personal party affiliations are, chaos will not reign tomorrow, next week, or in the future, provided you individual physicians and surgeons continue to actively participate in this republic's government, preferably with collective action.

▶ Dr. Welch, 7575 S.W. 62nd Avenue, Miami 33143.

AMA Clinical Convention

Francis N. Cooke, M.D.

The Dade County Medical Association will play the role of host for the 1968 American Medical Association Clinical Convention to be held in the newly expanded Convention Hall, Miami Beach, Florida. The dates will be Sunday, December 1 through Wednesday, December 4, 1968.

In addition to the interim sessions of the House of Delegates there will be a scientific program with a variety of subjects which should be tremendously interesting to all Florida physicians. Three general sessions, each morning and afternoon, will include such subjects as the anemias and diseases of the lymphatic system, newer approaches in cardiology, cardiac arrhythmias, cardiac pacers and cardioversion. One three-hour session will be devoted to sex, marital problems, education and so forth; vascular disease, proctology and dermatology are other subjects to be discussed by experts from all sections of the country.

For those of you interested in postgraduate courses there are courses in diabetes, fluid electrolyte balance and thyroid disease. Morning live television shows and afternoon movies showing the latest medical and surgical techniques will help round out the program.

Advance registration cards are available if they have not already been mailed to you.

Register now and avoid the rush. Remember the dates: December 1st through 4th, 1968, Miami Beach, Florida.

▶ Dr. Cooke, 430 Ingraham Building, Miami 33132.

Dr. Cooke is president of the Dade County Medical Association.

Our Mail

Contribution of Dr. Cason

I am happy to compliment you on your August edition of the Journal with its highly interesting historical section.

While the name of the late Dr. Turner Z. Cason is mentioned in the article by Dr. Mark V. Barrow, it has occurred to me a number of times that there is insufficient appreciation for the work of Dr. Cason in initiating and persistently boosting the idea of a medical school at the University of Florida. A historical fact in this regard is that Dr. Cason, Dr. George Tillman of Gainesville and I were appointed as a committee and originated and set up the postgraduate medical seminars that were maintained for a period of 25 years. During that time Dr. Tillman died and now Dr. Cason is gone. The postgraduate school of medicine was in fact Dr. Cason's office where his contact with the president of the University of Florida and medical schools throughout the East and South made it possible for us to have such excellent programs at the seminars. It is interesting to note that the first seminar had on its staff of lecturers Dr. W. W. Babcock, who was chairman of the department of surgery, Temple University; Dr. John Kolmer of Johns Hopkins, Dr. Coakley of New York City and several others of national reputation.

Personally, I feel that the Florida Medical Association should do something to bring to the attention of the Board of Regents the untiring efforts of Dr. Cason in his endeavor to bring to Florida the finest medical men available for lecturers and at the same time to persistently urge the establishment of the College of Medicine. I believe that a building or a lecture room in one of the buildings of the J. Hillis Miller Medical Center at the University of Florida should be named for the late Dr. Cason.

Much of what I have said above can be verified by Dr. Edward Jelks, one of the three medical men who operated Riverside Hospital in Jacksonville, and no doubt, Dr. W. C. Thomas, Sr., of Gainesville.

T. H. Bates, M.D.
Lake City



Dr. Cason



This senior from Florida State University, Miss Martha Grove, did this month's cover. Miss Grove lives in Coconut Grove. She was named "most distinguished student" in Fashion Design at F.S.U. We greatly appreciate this pictorial comment on America, especially since it comes from the point of view of awakened youth.

The Bettman Archive



Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

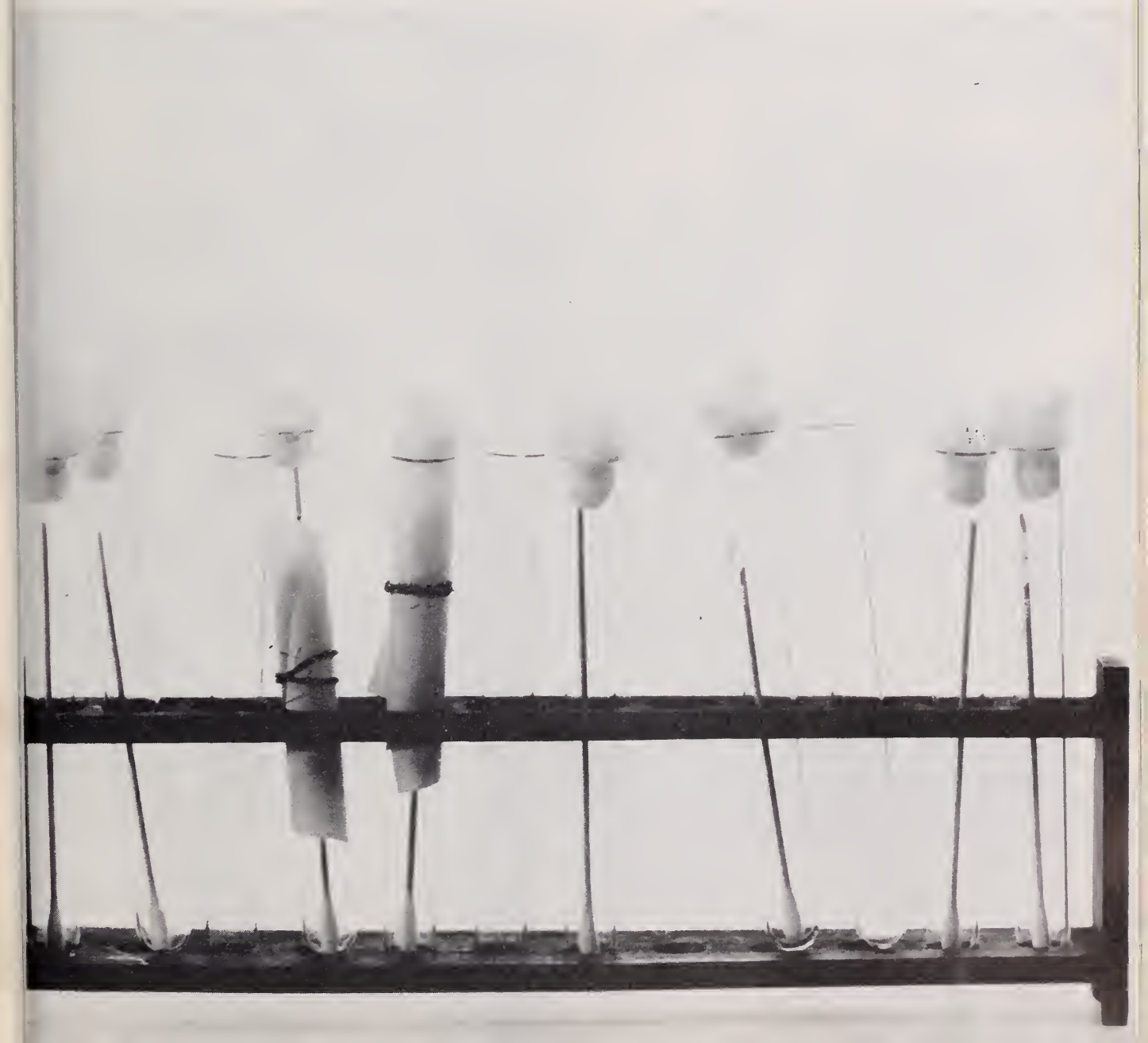
Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE
Lederle

The price differential is inconsequential.




ORRY
FEAR
FEAR
09209
bills
GENERAL HOSPITAL
U. S. TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE
Bonds
worries

When life's pressures build up blood pressure

in the hypertensive patient

She's 60 and she's worried—worried about coping with life's pressures and frustrations at her age and worried about her hypertension. Learning to live with hypertension won't be easy for her, but you can prescribe assistance in the form of HYDROPRES® to help control emotional fluctuations of blood pressure.

HYDROPRES, a combination of two proven antihypertensive agents, has a mild tranquilizing effect that lets the patient relax as it reduces blood pressure. It helps alleviate symptoms associated with hypertension, such as headache and tachycardia, that frequently reflect the general tenseness of the patient.

It's worth noting that potassium loss with HYDROPRES at usual therapeutic doses is usually minimal, and a diet rich in potassium normally avoids serious depletion.

Another point to remember: When other antihypertensive drugs are used adjunctively they must be given at one half their usual dosage simply because HYDROPRES potentiates the action of such agents. HYDROPRES is contraindicated in anuria and in patients known to be sensitive to hydrochlorothiazide or reserpine.

So, when life's pressures build up blood pressure, consider HYDROPRES to help your hypertensive patient feel more relaxed while under pressure.

HYDROPRES®

ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES-50:
50 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

helps your patient relax as it lowers her blood pressure

For additional prescribing information, please see following page.

INDICATIONS: Mild to severe hypertension.

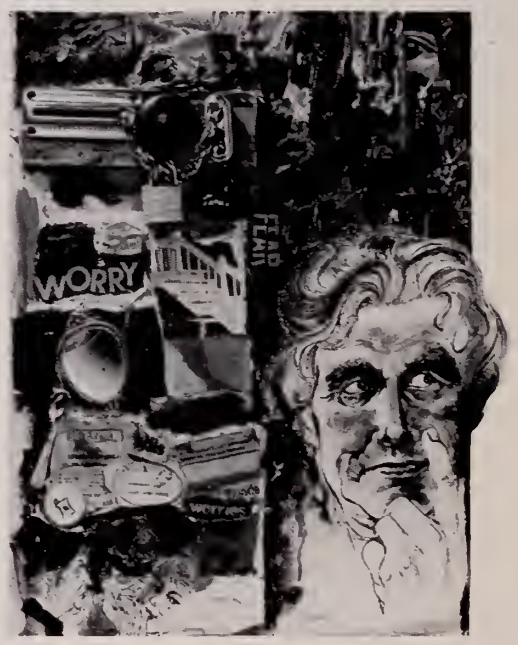
CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to hydrochlorothiazide or reserpine. Active peptic ulcer and ulcerative colitis. Nursing mothers. If drug is essential, patient should stop nursing. Active mental depression, especially with suicidal tendencies. Electroshock therapy; discontinue drug at least 7 days before initiating electroshock therapy.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis. Dosage of other antihypertensive drugs, especially ganglion blockers, must be reduced by at least 50 percent because HYDROPRES potentiates their action. A further reduction in dosage or even discontinuation of the other antihypertensive drugs may be necessary as blood pressure falls. Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery frequently required and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.
Consider possibility of sensitivity reactions in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives (including thiazides) and reserpine. Discontinue at first sign of depression. Nasal congestion, lethargy, depressed Moro reflex, and bradycardia may appear in infants born of reserpine-treated mothers. Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: Hydrochlorothiazide: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive, or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant steroid or ACTH therapy, or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypochloremic alkalosis occurs infrequently and is rarely severe. If dietary salt is unduly restricted, especially during hot weather, in severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. Insulin requirements in diabetics may be altered. May produce hyperglycemia and glycosuria in latent diabetics. **Reserpine:** Since reserpine may increase gastric secretion and motility, it should be used cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones, or bronchial asthma in susceptible patients. May cause hypotension, including orthostatic hypotension. Since significant hypotension and bradycardia may develop during anesthesia, discontinue two weeks prior to surgery. For emergency surgery, vagal blocking agents parenterally may be needed. Anxiety, depression, or psychosis may develop. Preexisting depression may be aggravated. Discontinue at first sign of mental depression. Use with extreme caution in patients with history of mental depression, noting possibility of suicide. Use caution when treating hypertensive patients with renal insufficiency, as they adjust poorly to lowered blood pressure levels. Use cautiously with digitalis and quinidine; cardiac arrhythmias have occurred with reserpine preparations.

ADVERSE REACTIONS: Hydrochlorothiazide: Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, jaundice. Nausea, vomiting, diarrhea, dizziness, vertigo, and paresthesias may occur. Purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions have been reported. Also, cutaneous vasculitis in elderly patients on repeated and continuing exposure to several drugs. Scattered instances of pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice have been reported. With moderate or severe reactions, thiazide dosage should be reduced or therapy withdrawn. **Reserpine:** Reactions most often reported include excessive sedation, nightmares,

helps your patient relax as it lowers her blood pressure



nasal congestion, conjunctival injection, enhanced susceptibility to co
muscular aches, headache, dizziness, dyspnea, anorexia, nausea,
creased intestinal motility, diarrhea, weight gain, dryness of mo
blurred vision, flushing of skin, pruritus. Skin rash, dysuria, syncope,
puerperal lactation, impotence or decreased libido, increased salivat
vomiting, bradycardia, mental depression, nervousness, paradox
anxiety, epistaxis, purpura due to thrombocytopenia, angina pect
other direct cardiac effects (e.g., premature ventricular contracti
fluid retention, congestive failure), and CNS sensitization manifested
dull sensorium, deafness, glaucoma, uveitis, and optic atrophy have
been noted. A Parkinson's disease-like syndrome, usually reversible
decreased dosage or discontinuance of therapy, has been observed.
cautiously in hypertensive patients with coexistent coronary ar
disease to avoid precipitous drop in blood pressure.

**For more detailed information consult your Merck Sharp and Dohme re
sentative or see the package circular.**

HYDROPRES

ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES-
50 mg. hydrochlorothia
0.125 mg. reserpine per ta

MERCK SHARP & DOHME | **where today's theory is tomorrow's thera**
Division of Merck & Co., Inc., West Point, Pa 19486



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.: phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

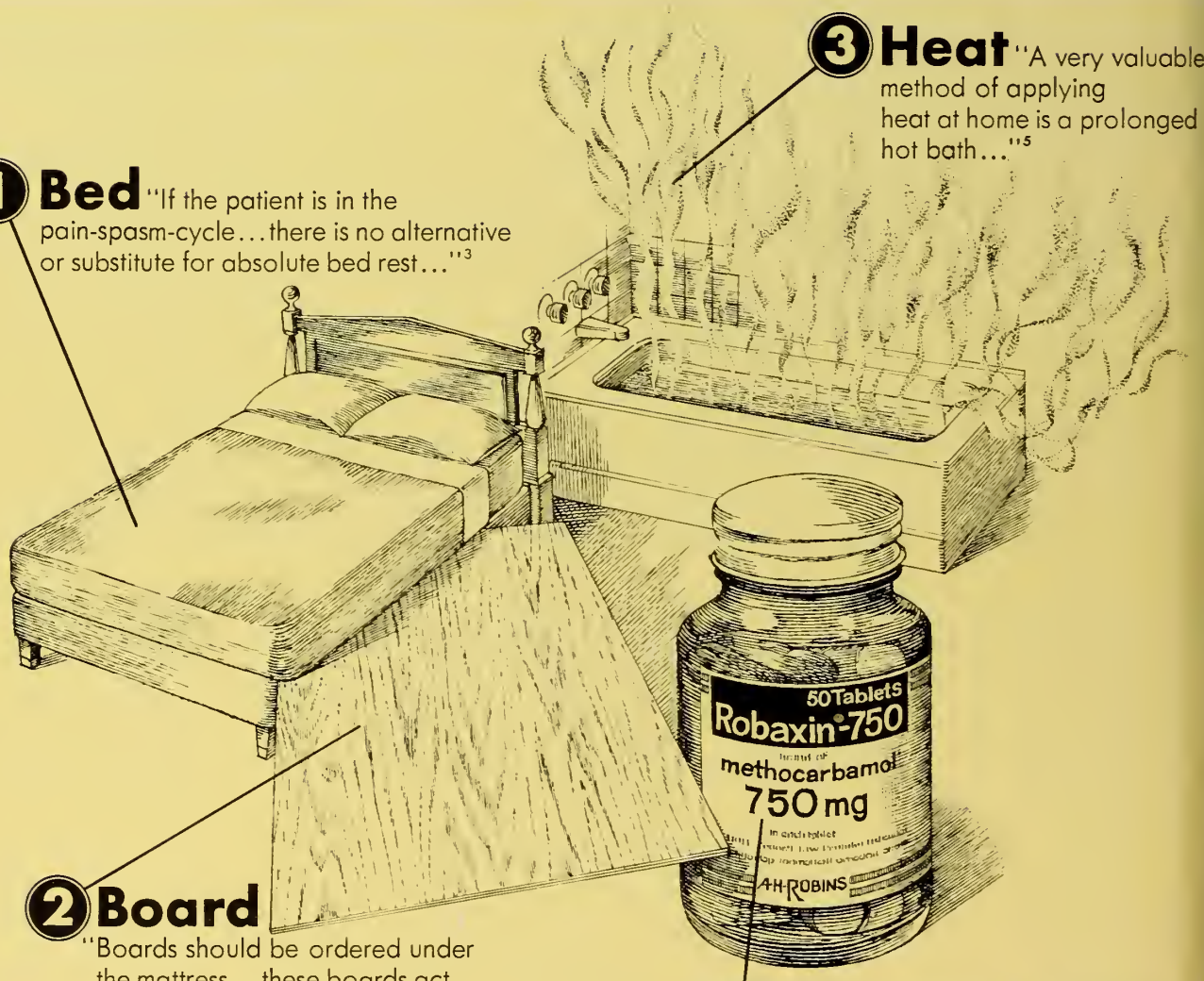
up to 10-12 hours clear breathing on one tablet



LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive potients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Roboxin® Tablets (methacarbomal, 500 mg.) Rabaxin Injectable (methacarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: South Dokato J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

A Modern Psychiatric Hospital . . .



This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

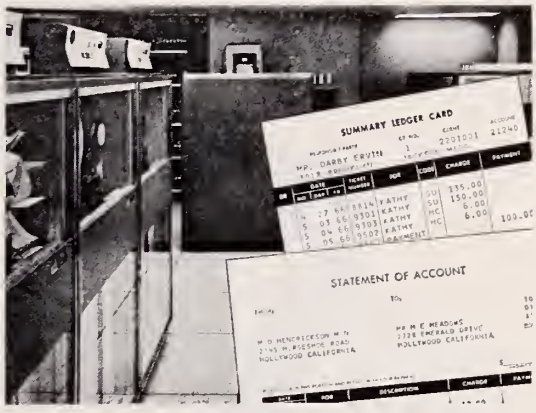
LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

Member American Hospital Association
Medicare Provider

AUTOMATED MANAGEMENT SYSTEMS OF FLORIDA, INC.

FIRST FEDERAL BUILDING
8340 N.E. 2ND AVENUE
MIAMI, FLORIDA 33138

Accounts receivable management system
designed specifically for doctors



This system offers doctors the advantage of computer techniques for accounts receivable maangement with no investment in equipment. All that's required from the doctor is a daily report voucher on each patient. From this, AMS furnishes a whole series of regular reports and analyses plus the preparation of each patient's monthly statement. The cost is usually far less than doing your own bookkeeping.

We are a National Concern serving Doctors for over seven years.

☐ Please send me your Accounts Receivable Management Brochure.

☐ Please have one of your consultants call me for an appointment.

Name

Addresss

City Phone



"Now that your acne is clearing up nicely, it might be a good idea if you started losing some weight."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8



AMA

22ND CLINICAL CONVENTION

MIAMI BEACH

DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting — the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

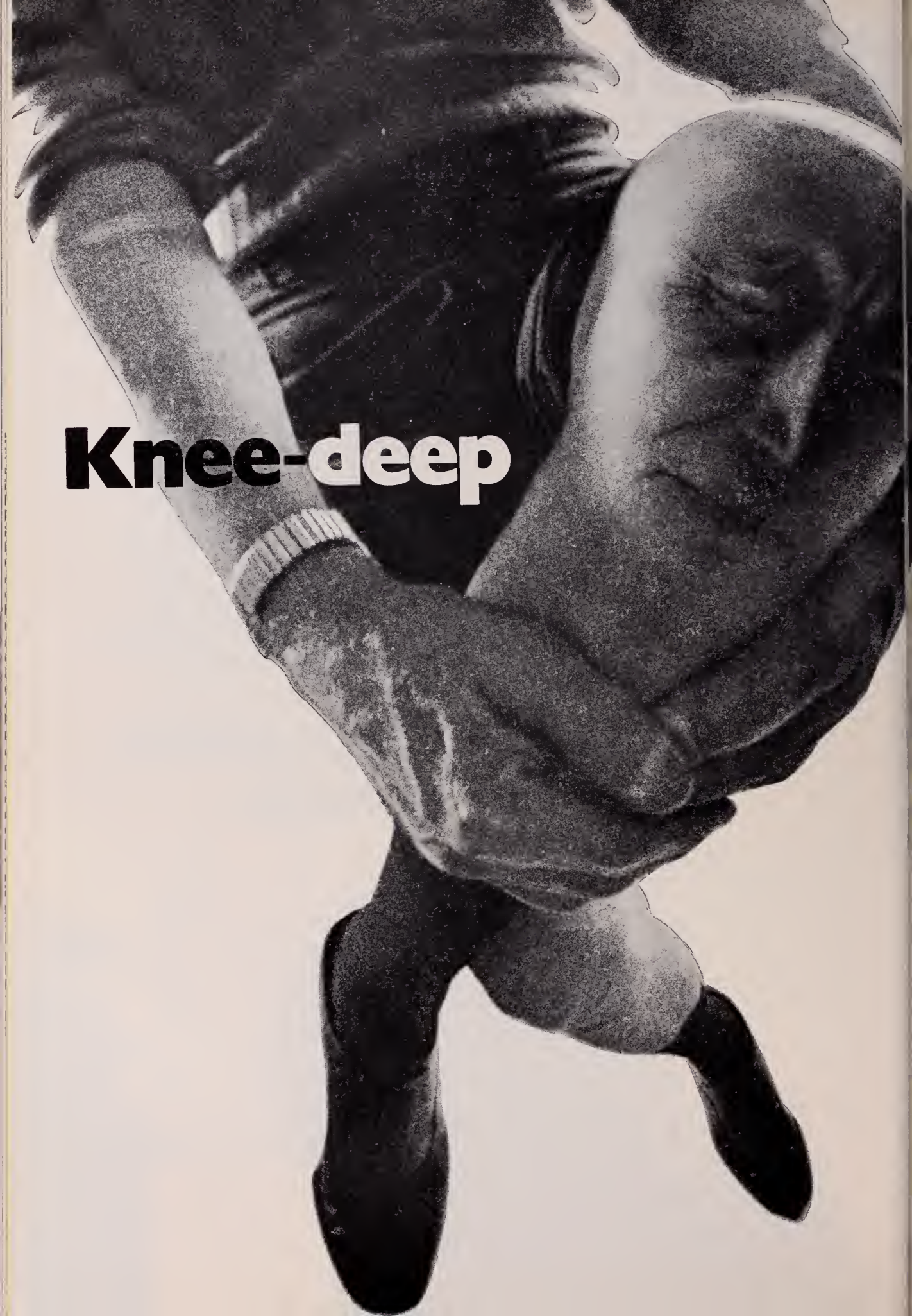
In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67




Knee-deep

n osteoarthritic pain

If aspirin doesn't help, move in th Tandearil.

The trial period is brief: 1 week. ly one tablet q.i.d. at first. Tandearil ually starts working within 3 to 4 days. hen response occurs, as little as 1 or ablets daily may hold back pain and ffness, and increase joint motion.

On the next page is a summary adverse reactions, contraindications, arning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

ndearil, oxyphenbutazone:
r brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



A little

Just one 50 or 100 mg tablet in the morning can work a long diuretic day in edema and hypertension.

HY-6060



Hygroton® can work a long day too

chlorthalidone

hat's because of its prolonged ction, which usually provides mooth diuretic activity roughout the day. And ne-a-day dosage means few ablets to take and few tablets pay for in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton

chlorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplasti anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashe urticaria, purpura, necrotizing angiiti acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every othe day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Florida Medical | medicolegal

Liability of Surgeon and Anesthesiologist

Harry T. Gray, LL.B.

The following legal opinion is in response to two questions raised by the Florida Society of Anesthesiologists.

The first question is that of legal responsibility or relationship to a patient who has been seen in consultation by a nurse anesthetist or technician and then administers the anesthesia. For example, the surgeon might request an anesthesiologist to see a patient in consultation the night before. He does see him and writes a consultation note but does not write any orders nor give any specific advice as to the management of the anesthesia. What would be this physician's legal responsibility should there be a problem directly related to the anesthesia? Also, is there a change in responsibility, should the anesthesiologist write the patient's medication orders the night before surgery, but again not participate in the anesthesia management?

The second question: What is the legal relationship of an anesthesiologist to the hospital simply because he is on the staff of that hospital? In other words, when an anesthesiologist comes into a small community hospital employing a group of nurses, does he by his mere presence there change the standards of practice in the community and also assume certain liabilities because of this change? —Ed.

We have studied the letter of Aug. 5, 1968 from the Florida Society of Anesthesiologists. You should know that the Supreme Court of Florida in 1958 (Dohr v. Smith, 104 So. 2d 29) ruled that the surgeon and the hospital are not responsible for the negligent act of the anesthesiologist, a doctor. Of course, should the surgeon observe a practice being followed which in his opinion is improper, it would be his legal duty to request the anesthesiologist to follow a proper practice.

Answering the first question, it is our opinion that a surgeon is responsible for the acts of the *anesthetist*, not a doctor but a nurse under the "Captain of the Ship Doctrine" [See page 957, October Journal]. If, however, the service is performed by a medical doctor, the surgeon would not be legally responsible. Again as to the physician's legal responsibility should there be a problem directly related to the anesthesia, a physician would be responsible under the "Captain of the Ship Doctrine" for the act of an anesthetist, a nurse, but would not be responsible for the act of a medical doctor, an anesthesiologist.

Finally, if the medication orders are written by the anesthesiologist correctly to be followed in the operating room by another person, the anesthesiologist would have no legal liability for failure to comply with his orders.

As to the second question, the relationship between an anesthesiologist to a hospital depends upon his services to the hospital either as a member of the staff or under some other relationship. We do not intend to infer that the anesthesiologist, simply because he is on the staff of the hospital, is responsible legally for the negligent act of an anesthetist. The doctor is only responsible for the activities in which he participates.

Mr. Gray is legal counsel, Florida Medical Association.

▶ Mr. Gray, P.O. Box 447, Jacksonville 32201.



One by one
the family's downed
Because the
G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

The Hole in the Picture

Donald L. Howie, M.D.

A jigsaw puzzle with pieces missing is always mildly upsetting. I usually search for the pieces, but I am only sometimes successful.

One afternoon I was called to the scene of an apparent suicide. The man's car was parked in the side yard of the church which he normally attended. He was lying supine between the car and a small outbuilding. Nearby was a single-barreled shotgun which the man had recently purchased in a local store. A large hole was present in the upper left quadrant of the abdomen, compatible with a shotgun wound.

History indicated the man had had a disseminated carcinoma and that he had been both despondent and in pain. A suicide note was present. The note was quite repetitious, almost to the point of perseverance, and appeared compatible to the existence of an organic brain syndrome. Upon autopsy there was discovered a disseminated tumor implanted in the dura with direct invasion of the cerebral cortex. The pellets from the shotgun blast had lacerated liver, spleen, bowel, diaphragm and lung.

The puzzle was complete except for one item. With the gun positioned along the apparent missile path, the man could not have reached the trigger. Furthermore, he had his shoes on. There were no instruments in evidence with which he could have discharged the gun. I left. About a mile down the road, curiosity overwhelmed me and I turned around and went back to the scene.

The grounds were well kept and there were no trees in the yard. There were trees in the adjacent field. On the ground, in the position over which the ambulance attendants had placed their stretcher, there was a forked stick about one foot long. The fork would have fitted the trigger. On handling the stick, small pieces of bark adhered to the hand. The deceased had identical pieces of bark adhering to his right palm. The puzzle now was complete.

▸ Dr. Howie, Mound Park Hospital, St. Petersburg 33731.





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

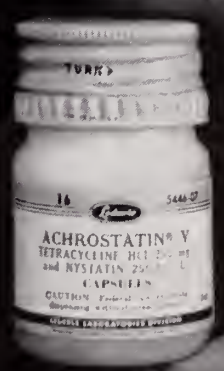
JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

From the First Family of Tetracycline– One of the 31 useful dosage forms in the ACHRO Family

ACHROSTATIN® V Capsules

Tetracycline HCl 250 mg /Nystatin 250,000 units



The lowest priced tetracycline-nystatin combination

Lederle

329-8/6094

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

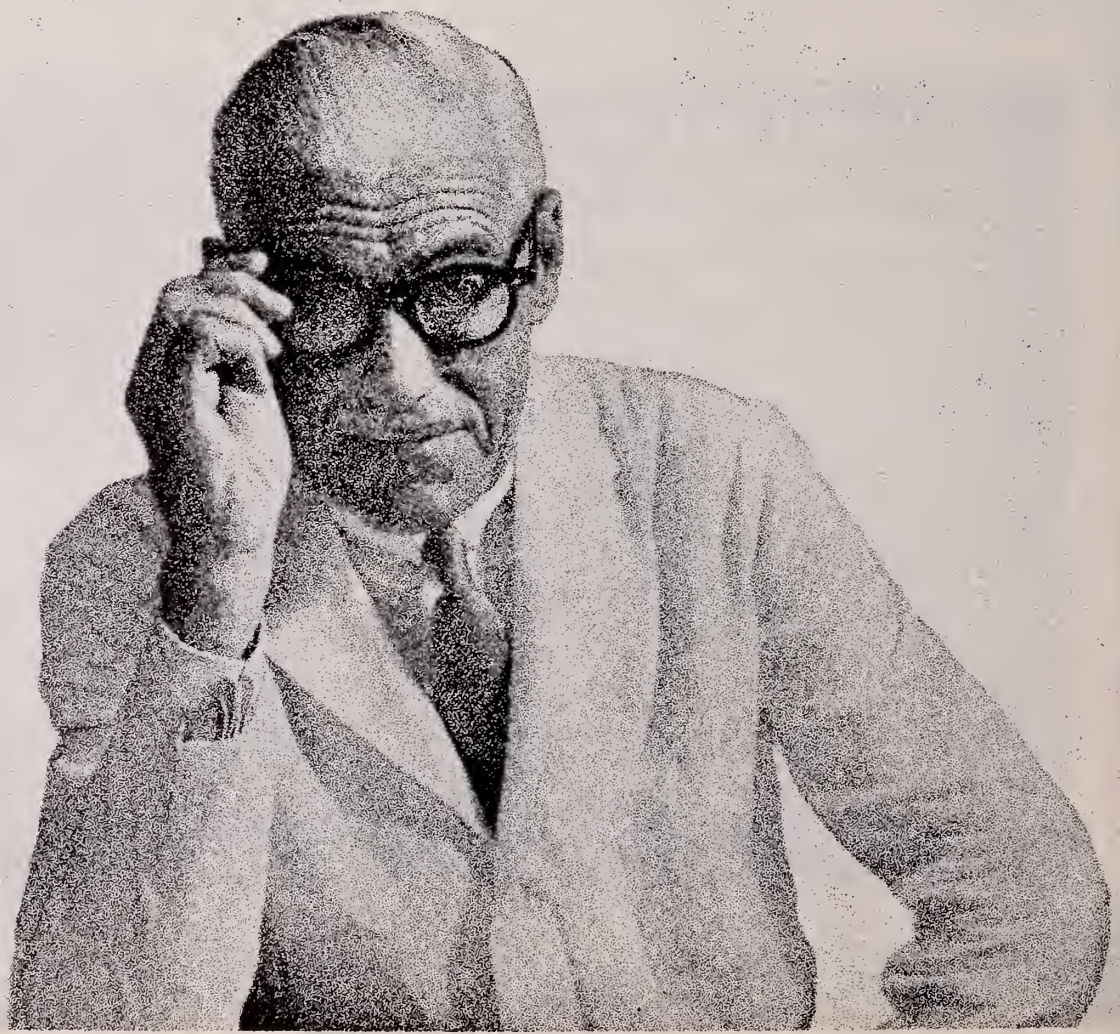
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

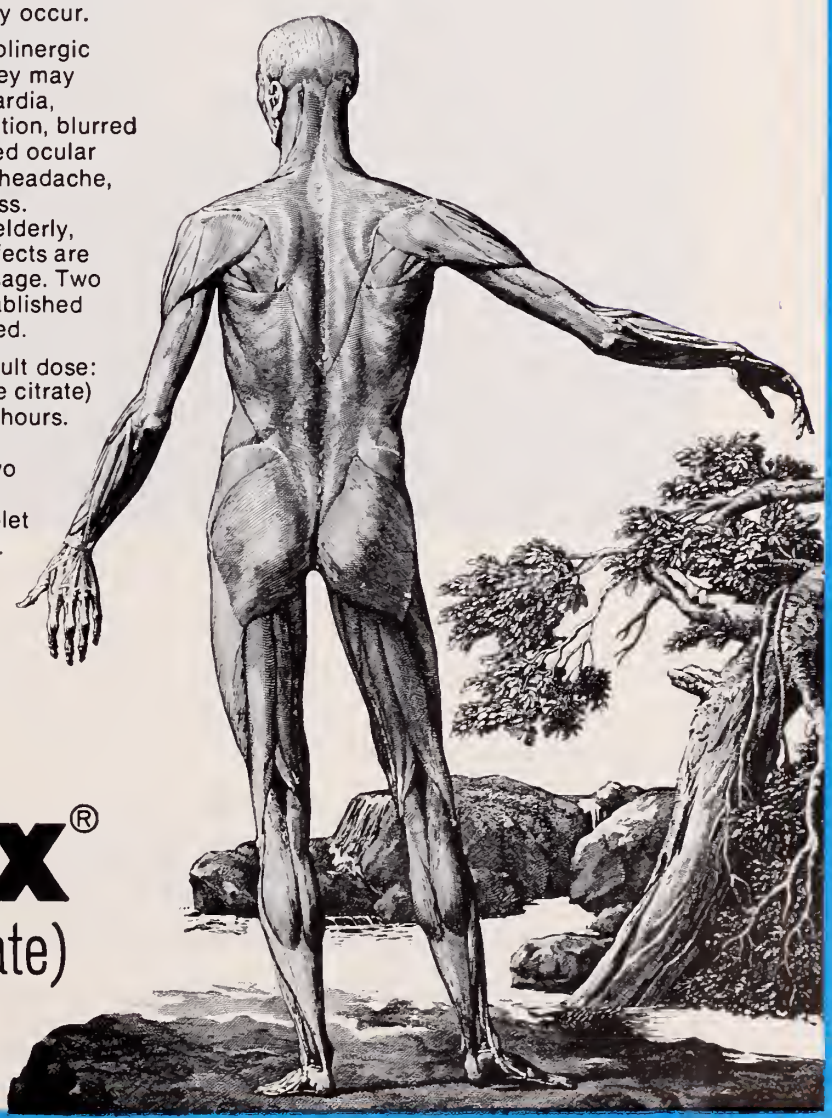
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains 15% alcohol†)
†Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound

Ayerst®

AYERST LABORATORIES • New York, N. Y. 10017 • Montreal, Canada 6837

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

A COMPLETE BUSINESS SERVICE

FOR THE MEDICAL AND DENTAL PROFESSIONS

Professional Management

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT since 1932 PM FOR PHYSICIANS AND DENTISTS

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



Louie lost weeks with acute shoulder bursitis. That's a lo
of pain, stiffness and tenderness...and also a lot of fisl
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."



TO-575

.Forlorn"

"Had a divorce."
"I'm a real loser,
and so are
the kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757



DOCTOR —

Would you like to present a scientific exhibit at the 1969 FMA Annual Meeting being held May 14-18 at the Americana Hotel, Bal Harbour?

The Committee on Scientific Assemblies is now accepting exhibit applications. Deadline for applications is January 1, 1969. An application form may be obtained by filling in your name and address below and mailing this page to Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203.

Yes, I am interested in presenting a scientific exhibit at the 1969 FMA Annual Meeting. Please send me an application form.

_____
(Name)

_____
(Address)

_____
(City)

This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial investment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.

Pharmaceutical Manufacturers Association
Pharmaceutical Advertising Council

1155 Fifteenth St., N. W., Washington, D.C. 20005



This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330-8/6135

Hill Crest HOSPITAL

(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

CONVENTION PRESS

2111 NORTH LIBERTY ST.
JACKSONVILLE, FLORIDA
32206

QUALITY BOOK PRINTING
PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

Thomas B. Slade — Fifty-two Years in Florida — J. Beatty Williams

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 — P. O. Box 2580 — 1050 W. Adams Street — Jacksonville, Fla. 32203



P. L. DODGE MEMORIAL HOSPITAL

M. G. ISAACSON, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 379-1448

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Florida Medical Association Officers and Council Chairmen

Officers

Jack Q. Cleveland, M.D., Coral Gables, President
Henry J. Babers Jr., M.D., Gainesville, President-Elect
Irving E. Hall Jr., M.D., Bradenton, Vice President
James T. Cook, M.D., Marianna, Speaker of the House
Charles K. Donegan, M.D., St. Petersburg, Vice Speaker
Floyd K. Hurt, M.D., Jacksonville, Secretary-Treasurer
W. Dean Steward, M.D., Orlando, Immediate Past President
W. Harold Parham, Jacksonville, Executive Director

Chairmen

James W. Walker, M.D., Jacksonville, Allied Professions and Vocations
John J. Cheleden, M.D., Daytona Beach, Judicial
Jere W. Annis, M.D., Lakeland, Legislation and Public Agencies
Jack A. MaCris, M.D., St. Petersburg, Medical Economics
James M. Ingram, M.D., Tampa, Medical Services
Richard C. Dever, M.D., Miami, Scientific Activities
William C. Roberts, M.D., Panama City, Special Activities
Joseph G. Matthews, M.D., Orlando, Specialty Medicine
Hawley H. Seiler, M.D., Tampa, Voluntary Health Agencies

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15.000: central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: Physician to do general practice with two established GP's for association and eventual partnership. 35-bed approved JCAH hospital soon to expand—with modern professional arts bldg. and northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

PHYSICIAN NEEDED; unique town, county per capita income $3,649. Very desirable place to live in. Modern office space, three examining rooms, laboratory and private office. Write P.O. Box 118, Clewiston, Fla. 33440.

WANTED: General practitioner to join group in N.W. Miami. Presently building own hospital and clinic. Guaranteed $24,000 first year. Energetic individual can earn considerably more. For details contact Dr. Oper, 13880 N.W. 27 Ave., Opa Locka, Fla. 33054 (phone) 688-6685.

WANTED: General practitioner for association with mixed group. Salary plus percentage and all expenses. Share coverage on day off, weekends, vacations. Guarantee $20.000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305) 636-4221.

URGENTLY NEEDED: GP to assist established but presently incapacitated physician in operation of 35-bed county hospital. Association or partnership if desired. Compensation open. North central Florida. Write C-850, P.O. Box 2411, Jacksonville, Fla. 32203.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

Specialists

WANTED: Internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Compensation open. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

INTERNIST WANTED: To join two-man "professional association" in greater Miami area. Salary open, tax-free pension or profit-sharing available. Share time off. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified to associate with two physicians in the greater Miami area. Salary open. Write C-845, P. O. Box 2411, Jacksonville, Fla. 32203.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd. W., Bradenton, Fla. 33505.

WANTED: Internal medicine practice opportunity for board eligible internist with subspecialty interest in Southeastern coastal community. Starting salary $21,000 first year with opportunity for full partnership. Write C-844, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified. Cardiology interest. In suburban Miami, Florida. Long established professional association to replace third man vacancy. Immediate opportunity. Salary negotiable. Corporation participation available after first year. Send curriculum vitae, age, marital and military status, licensure and financial interest to C-860, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Partnership-internist to head department of large established Lauderdale practice. Excellent facilities, new building with unusual ancillary services. Write C-848, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Winter Haven, Polk County, central Florida, home of Cypress Gardens. ENT man sought to join four physicians, two dentists, lab technician and pharmacist who have built new medical complex. Option to buy into corporate structure after probationary period. Professional and economic independence. Write C-840, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

EMERGENCY ROOM PHYSICIANS for southeast Florida hospital. Must have Florida license. $22,000 minimum. Positions available immediately. Write C-854, P.O. Box 2411, Jacksonville, Fla. 32203.

G. P. OR INTERNIST for immediate association in an active practice. Financial and other details open for agreement. Call collect, R. H. Shedd, M.D. (813) 639-1640.

WANTED: Physicians to practice full time emergency medicine. Advantages we have to offer at present time: (1) Regular hours (2) Reasonable remuneration (3) Excellent growth potential. If interested, send confidential reply to C-857, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST OR GP: North Miami Beach, Fla. $18,000 start—leads to association. Contact Mr. Harold Kwart, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GP OR INTERNIST to associate with three-man group, one surgeon and two GP's. Suburban Jacksonville. 30,000 first year to approximately $40,000 in two years of partnership as agreed. Call Dr. M. B. Bergh, (904) 264-9511.

WANTED: GP or general surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Florida licensed physician, experienced in all phases of general medicine, especially surgery, for association with board general surgeon-gynecologist. Excellent salary with partnership after two years. Write C-856, P.O. Box 2411, Jacksonville, Fla. 32203.

EMERGENCY ROOM PHYSICIANS: Two vacancies to join five-man group; full time, no private practice allowed; fee for service, $20,000.00 annual minimum. Florida license required; modern 500-bed hospital; 25,000 emergency room visits annually. Teaching hospital with an active approved internship-residency program. For additional information write: Sherwood D. Smith, Executive Director, P. O. Drawer 448, Lakeland, Florida 33802.

WANTED: Emergency room physician in hospital; to join group of private physicians, 42 hour week, income $20,000 plus. Contact Bruce S. Webster, M.D., 1416 South Orange Ave., Orlando, Fla. 32806. Phone 647-5728.

situations wanted

POSITION WANTED: Indiana University (AOA) radiology resident, age 30, military service completed, seeks radiology group position for July 1969. Have Florida license. Write C-846, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST-CARDIOLOGIST. Board eligible, university trained, seeks clinical association with internist, group or hospital with opportunity for catheterization and/or coronary care unit work. Available August 1969. Write C-852, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL SURGEON: Board certified, licensed in Florida 1968. Desires association with another surgeon or group in a coastal city of central or southern Florida. Write C-855, P.O. Box 2411, Jacksonville, Fla. 32203.

practices for sale

FOR SALE OR LEASE: Active practice 21 years. Spacious 12 room modernly equipped establishment, new 62-bed hospital in Sebring, Fla. Contact Stanley K. Wallace, M.D., 32 N. Commerce St., Sebring, Fla. 33870. Telephone 385-8640.

FOR SALE: General practice (intact), office building and equipment. Available immediately in Fort Lauderdale, Florida. Write C-858, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTICE in Cape Kennedy area; established 5 years; grossing $70,000; excellent opportunity; potential $100,000. No cash necessary; all supplies and equipment. Will introduce; agreeable terms. Write C-859, P.O. Box 2411, Jacksonville, Fla. 32203.

real estate

FOR RENT: Medical office complete. New. Rent free to December 1968. Write Suite 111, 4800 N.E. 20th Terrace, Fort Lauderdale, Fla. 33301.

MEDICAL OFFICE FOR RENT: Pensacola, Florida. New office across from Baptist hospital. 1 000 sq. ft. Carpeted throughout. Completely modern. Furnished or unfurnished. Available Jan. 1. Write C-851, P.O. Box 2411, Jacksonville, Fla. 32203.

NURSING HOME INVESTMENT: Doctors wanted to invest with me in a modern nursing home (I am the administrator) which can be bought at a low price from absentee owners due to death of a principal stockholder. Write C-853, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: One office left in beautiful new medical office complex across the street from community hospital expanding to 175 beds in near future. 1,200 sq. ft., 3 examining rooms, laboratory and private office, or can build to suit. Unique option to purchase shares in corporation. Excellent opportunity for generalist or specialist all fields. Medical Gardens of Venice, Inc., 209 Palermo Place, Venice, Florida 33595. Phone (305) 488-7716.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Florida Medical advertisers

Anderson Surgical Supply Co. 1054
Automated Management 1035
Ayerst Laboratories
Mediatric 1048-1049
Bradley Center 1022
Breon Laboratories
Fergon 1022
Bristol Laboratories
Tetrex F 992
Burroughs-Wellcome Co.
Empirin 1042a
Campbell Soups 1022a
Convention Press 1054
Eaton Laboratories
Furacin 990
Geigy Pharmaceuticals
Butazolidin 1050a
Hygroton 1042a
Tandearil 1040-1042
Tofranil 1050a
Guild of Prescription Opticians 994
Highland Hospital, Inc. 1050
Hill Crest Hospital 1053
Hynson, Westcott & Dunning, Inc.
Lutrexin 987
Lakeland Manor 1035
Lakeside Laboratories
Imferon 1059
Lederle Laboratories
Achromycin 1030-1031
Achrocidin 1018a
Achrostatin 1045
Bamadex 1036-1037
Declomycin 988
Histoplasmin Tine Test 1050
Peritinic 999
Tuberculin Tine Test 1053
Eli Lilly & Co.
Keflin 1022a
Trinsicon 994a
V-Cillin K 1002
Medical Supply Co. 1045
Merck, Sharp & Dohme
Elavil 998
Hydropres 1032-1034
National Drug Co.
Quinamm 1030
Parke-Davis & Co.
Dilantin 1039
Povan 996-997
Pitman-Moore
Novahistine 1000-1001
P. L. Dodge Memorial Hospital 1054
PM of Florida 1050
William P. Poythress & Co.
Trocinate 999
Riker Laboratories
Norflex 1047
A. H. Robins, Inc.
Dimetapp, Robaxin-750 ..... 1034a
Robinul Forte 1020-1021
Robitussin 1045
Roche Laboratories
Librium ..... Back Cover
NCME-TV 986
Valium 1042a
Wm. H. Rorer, Inc.
Parepectolin 1044
Sandoz
Mellaril 1050a
G. D. Searle Co.
Lomotil 1022a
Strasenburgh Laboratories
Omni-Tuss 1018a
Stuart Co.
Mylanta 994a
Surgical Supply Co. 1054
Tucker Hospital, Inc. 1055
Warner Chilcott Laboratories
Sinutab 1019
Winthrop Laboratories
NTZ 994a
Wyeth Laboratories
Pen Vee K. 995

IRON DEFICIENCY

ANEMIA



Each 10 cc. vial provides as much iron as 2 pints of whole blood. And use of IMFERON rather than whole blood for iron replacement eliminates the potential dangers of hepatitis and whole blood sensitivity reactions. Whole blood, of course, should be used if clearly indicated.

IMFERON dependably increases hemoglobin and rapidly replenishes iron reserves—for iron deficient patients in whom oral iron is intolerable, ineffective or impractical, and in those who cannot be relied upon to take oral iron as prescribed. Precise dosage is easily calculated.

IMFERON®

(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a source of iron; infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

See package insert for complete prescribing information.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Whenever anxiety induces or intensifies clinical symptoms

Librium®

(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination,on proper dosage~Has wide margin of safety

LIBRARY
NOV 12 1963
OF MEDICINE

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

NY ACADEMY MED LIBRARY
2 EAST 103RD ST
NEW YORK NY 10029

ide) 5-mg, 10-mg, 25-mg tablet

THE JOURNAL OF THE
Florida Medical ASSOCIATION
DECEMBER, 1968 • VOLUME 55 • NUMBER 12

OFFICIAL PUBLICATION OF THE FLORIDA MEDICAL ASSOCIATION, INC.

M D



Design for an ear anti-infective

Designed to act promptly against bacterial pathogens and pain

Otitis media (when the tymponic membrone is perforated) ond otitis externo both respond to the boctericidol action of Furacin® (nitrofurazone) in Furocin-HC (nitrofurozone-hydrocortisone) Otic. Its brood ontibocteriol spectrum includes most of the orgonisms encountered in surfoce infections (but only certoin stroins of Pseudomonos). The hydrocortisone component in Furocin-HC Otic offords ropid relief of painful swelling.

Designed to let the ear drain freely

The water-soluble bose of Furacin-HC Otic permits free droinoge ond provides o hygroscopic vehicle.

Designed to please and protect the patient

Topicol Furacin-HC Otic lets you reserve systemic preparotions for systemic infections. It rorely irritates inflomed epitheliol surfoces, ond cross resistonce or cross sensitizotion with ontibiotics does not occur. In oddition, nonmacerating, odorless Furocin-HC Otic softens wox to focilitote removol of cerumen.

Also ovailable: Furacin® Otic (nitrafurazane with nifuraxime and diperodan HCl). The wide antibacterial range af Furacin is augmented by the antimycatic activity af Micafur® (nifuraxime). Diperadan hydrachlaride, an efficient local anesthetic, pramptly subdues pain and itching. Indicated in bacterial atitis externa, atamycosis or bacterial atitis media (when the eardrum is perforated).

Precautions: Sensitizatian ta nitrafurazane may occur with prolanged use and is mare likely ta develap in eczemataus atitis externa. Ta minimize such reactions (a) limit applicatian ta a week or less, and (b) avaid use of excessive amounts which may run dawn the face.

This preparatian is nat indicated far use in treatment af cholesteatama, where surgical interventian is necessary.

Contraindications: The usual contraindicatians far preparations containing hydrocortisone shou be abserved, such as tuberculaus lesians af skin ar ear, acute herpes simplex, vaccinia and varicella, superficial fungus and yeast infections.

Formula: Furacin®-HC Otic contains 0.2% Furacin, brand af nitrafurazane, and 1.0% hydra cartisane acetate in a water-saluble hygrascapic base of glycerin and palyethylene glycol.

Furacin® Otic contains 0.2% Furacin, brand af nitrafurazane, 0.375% Micofur®, brand of nifuroxime, and 2% diperodon hydrochlaride dissalved in water-saluble, nandrying, hygrascopic palyethylene glycal.

™Originators and Developers of The Nitrofurans
EATON LABORATORIES
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK 13815

Furacin®-HC Otic
nitrofurazone / hydrocortisone

Furacin® Otic
nitrofurazone with nifuroxime and diperodon HCl

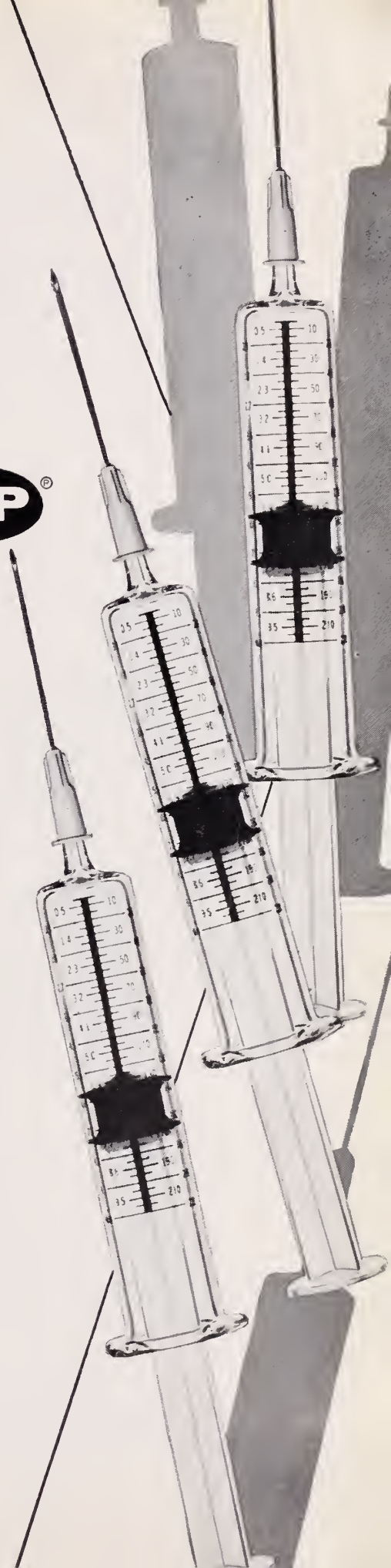


BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

THE JOURNAL OF THE
Florida Medical
ASSOCIATION
DECEMBER, 1968 • VOLUME 55 • NUMBER 12

scientific

Indications for Cardiac Pacing in Acute Myocardial Infarction 1079
PHILIP SAMET, M.D.
Preliminary Experience With a New Postganglion-Blocking Agent for the Management of Hypertension 1081
MARTIN S. BELLE, M.D., HUGH R. GILMORE, M.D., MACEY H. KEYES, M.D. AND HOWARD SANFORD, M.D.
Mental Health in the Public Schools—A Psychiatrist's View 1085
SAMUEL I. GREENBERG, M.D.
Failure and Frustration—A Tale of Clinical Research 1088
ASA L. GODBEY JR., M.D. AND RICHARD I. HENDRA, M.D.
Comparative Studies With 0.025% Fluocinolone Acetonide Cream and 0.2% Fluocinolone Acetonide Cream 1091
RICHARD S. FLATT, M.D.
Editorial Comment, JOSEPH FARRINGTON, M.D. 1093
Papilledema, Its Relationship to State of Responsiveness in Chronic Subdural Hematoma 1094
ALBERT W. AULD, M.D., DONALD M. DOOLEY, M.D. AND IRWIN PERLMUTTER, M.D.

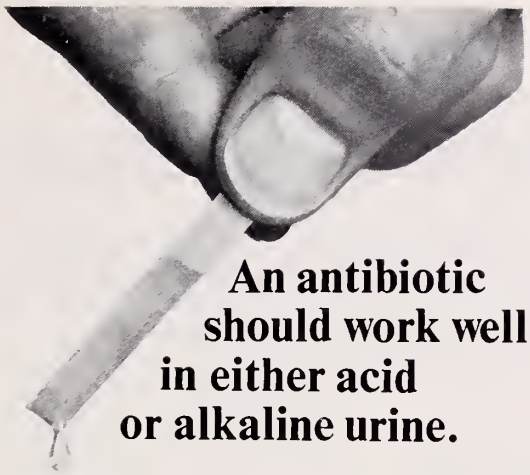
sections

Comment 1098
Deaths 1115
Editorial 1075
Medicolegal 1076
President's Page 1069

information

Advertisers 1127
Classified 1124
Florida Medical Association Officers and Council Chairmen 1126
Index to Volume 55 1120
Information for Authors 1067
Meetings 1108

Owned and published by the Florida Medical Association, Inc., P.O. Box 2411, Jacksonville, Florida 32203. The Journal is not responsible for the opinions and statements of its contributors. Published monthly at Jacksonville, Florida. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

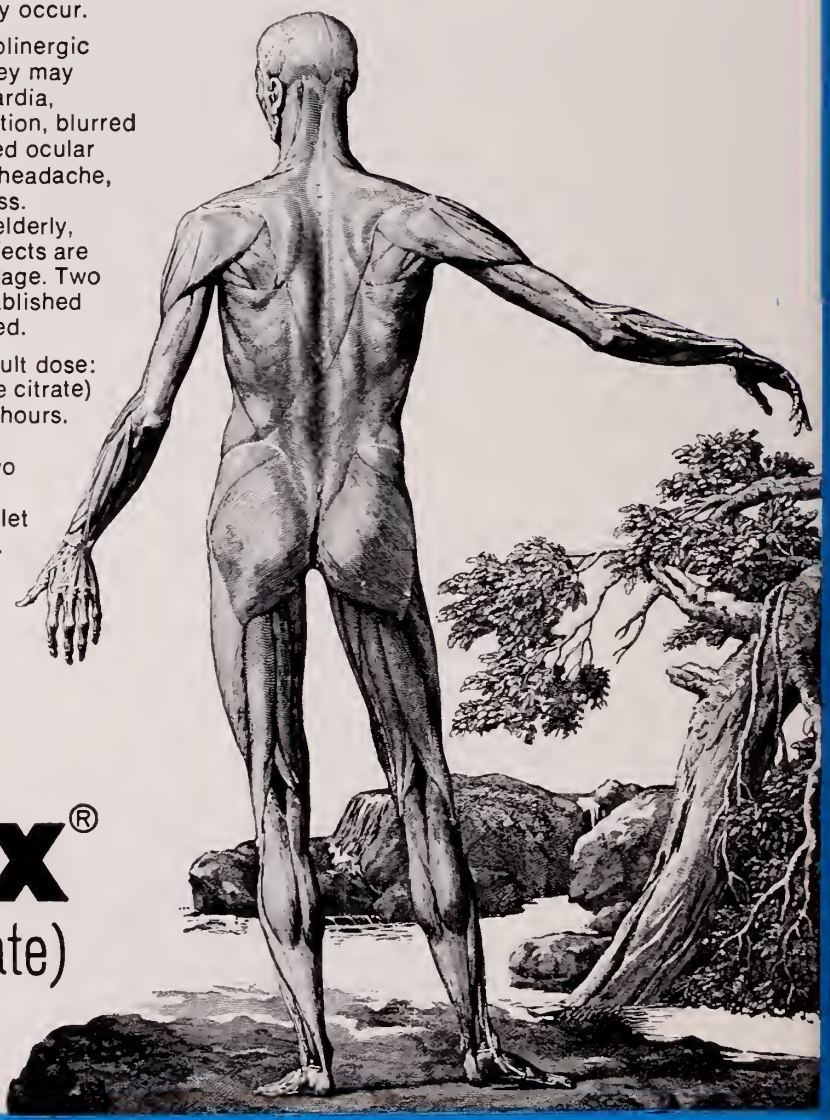
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)

Information for Authors

Manuscripts submitted for publication in the Journal of the Florida Medical Association should be double or triple spaced on white bond, including title page, illustration legends, tables and table headings, footnotes and references. Only original papers not previously published are considered for publication. Manuscripts submitted for publication are subject to review and approval by the Journal Publications Committee. All manuscript pages should be numbered consecutively. Within the manuscript, numbers one to ten should be spelled out except when used for units of measurement; for numbers above ten, arabic numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific (generic) names for drugs should be used when possible. Copyright or trade names should be capitalized when used. Submit *original* manuscript and two copies. Copying by electrostatic dry process (not wet process) is preferred to tissue copies. Retain one additional copy in your office for proofreading. All material is submitted with the understanding it is subject to editing.

Titles should be short, specific and clear. Omit phrases such as "The Use of," or "Observations on." If paper was presented at a meeting, indicate name of organization, city, month, day and year.

Photographs should be submitted as 5x7 glossy prints, untrimmed and unmounted; number each photograph *lightly* on the back with pencil and indicate top.

Line art such as charts, graphs and medical illustrations should be submitted as india ink drawings on white gloss paper; remember to make details large enough to allow for photographic reduction.

It is a policy of the Journal that authors pay for any cuts used to illustrate their papers.

References should conform to the style of the Index Medicus: name of author, title of article, name of publication with volume, page numbers, month and year. Example: McCollough, N. C.: Emergency Room Treatment of Venomous Snakebite, J. Florida M. A. 55:317-318 (April) 1968. References should be typewritten, double or triple spaced, beginning on a new sheet of paper entitled "References." Number references in the text in order of citation and prepare bibliography in the same order. Use superscript arabic numerals to cite references. Authors are responsible for the accuracy of bibliographies. The Journal Publications Committee reserves the right to pass upon the publication of any bibliography. Unusually lengthy bibliographies may be referred to at the end of the text with the statement "References are available from the author upon request."

Other Information

Subscription price: $7.00 per year; single number. 70 cents. Volumes begin with the January issue. Subscriptions may commence at any time. Back numbers, when available, may be obtained at a slightly increased cost based upon age and availability. Address Journal of the Florida Medical Association, P.O. Box 2411, 735 Riverside Avenue, Jacksonville, Fla. 32203. Telephone (904) 356-1571.

Microfilm editions available beginning with the 1967 volume. Address inquiries to University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Display advertising rates, as periodically published by the State Medical Journal Advertising Bureau, Inc., Chicago, of which the Journal is a subscriber, are available upon request.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less and 20 cents for each additional word.

Deadline for all material is the first of the month preceding month of publication. Acceptance of advertising is contingent upon approval of the Journal Advertising Committee.

THE JOURNAL OF THE Florida Medical ASSOCIATION

FRANZ H. STEWART, M.D.
Editor

CLYDE M. COLLINS, M.D.
Assistant Editor

OSCAR W. FREEMAN, M.D.
Assistant Editor

RICHARD M. FLEMING, M.D.
Assistant Editor from the Board of Governors

WILLIAM M. STRAIGHT, M.D.
Medical History Editor

EUGENE L. NIXON
Managing Editor

LOUISE RADER
Assistant Managing Editor

THOMAS R. JARVIS
Editorial Consultant



DECEMBER COVER

The newcomer to Florida at Christmas is likely to miss the snow, the sleigh bells of other times; yet, what is more characteristic of the decorations of this season than is the poinsettia—a plant common in Florida! We are indebted again to Kenneth DeGarmo.

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.



Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of

LOMA LINDA FOODS

MEDICAL PRODUCTS DIVISION

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio, U. S. A.





Ingredients of Healing

Honour a physician with the honour due unto him for the uses which ye may have of him: for the Lord hath created him.

For of the Most High cometh healing, and he shall receive honour of the king.

The skill of the physician shall lift up his head: and in the sight of great men he shall be in admiration.

THE APOCRYPHA
ECCLESIASTICUS 38:1-3

The art of healing is a natural craft conceived in sympathy and born of necessity. The earliest medical men were, as some may still be, magicians, sorcerers, and witch doctors. Yet during Egypt's prime, three thousand years ago, medicine was so highly organized that specialization had already begun. Herodotus, the Greek historian, observed of the Egyptians,

> "The art of medicine among them is distributed thus: each physician is a physician of one disease and no more—and the whole country is full of physicians."

Before 400 B.C. the system that eventually became Western Medicine was developing under Hippocrates, "The Father of Medicine," in Greece. He set the pattern for professional attitudes and ethics, taught that observation and deduction were more important than textbook treatment, and emphasized the healing power of nature.

Later the Renaissance dispelled much of the darkness of the preceding ten centuries and gave to medical investigation a new lease on life. Artists specialized in anatomy and dissection, chief among them being Leonardo da Vinci. Paracelsus stimulated the revolt against dogmatism and roused men to seek new knowledge. Vesalius in the 16th Century was famed for the accuracy of his anatomical descriptions. William Harvey in the 17th Century founded modern physiology. Every physician who listens to a chest will forever be in debt to Laennec who invented the stethoscope in 1816.

It is the 20th Century, however, that has brought the unbelievable progress in medical knowledge.

In spite of this, sympathy and love identified with the healing acts of Jesus and concern for the sick are ingredients that must not be missing in treating the ills of mankind.

MERRY CHRISTMAS!

Much of the above is contained in "Search the Scriptures" by Dr. Robert Greenblatt.

Jack A. Cleveland



When she gets a bacterial infection, think of Tetrex-F.®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



Louie lost weeks with acute shoulder bursitis. That's a lo
of pain, stiffness and tenderness...and also a lot of fish
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-B

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

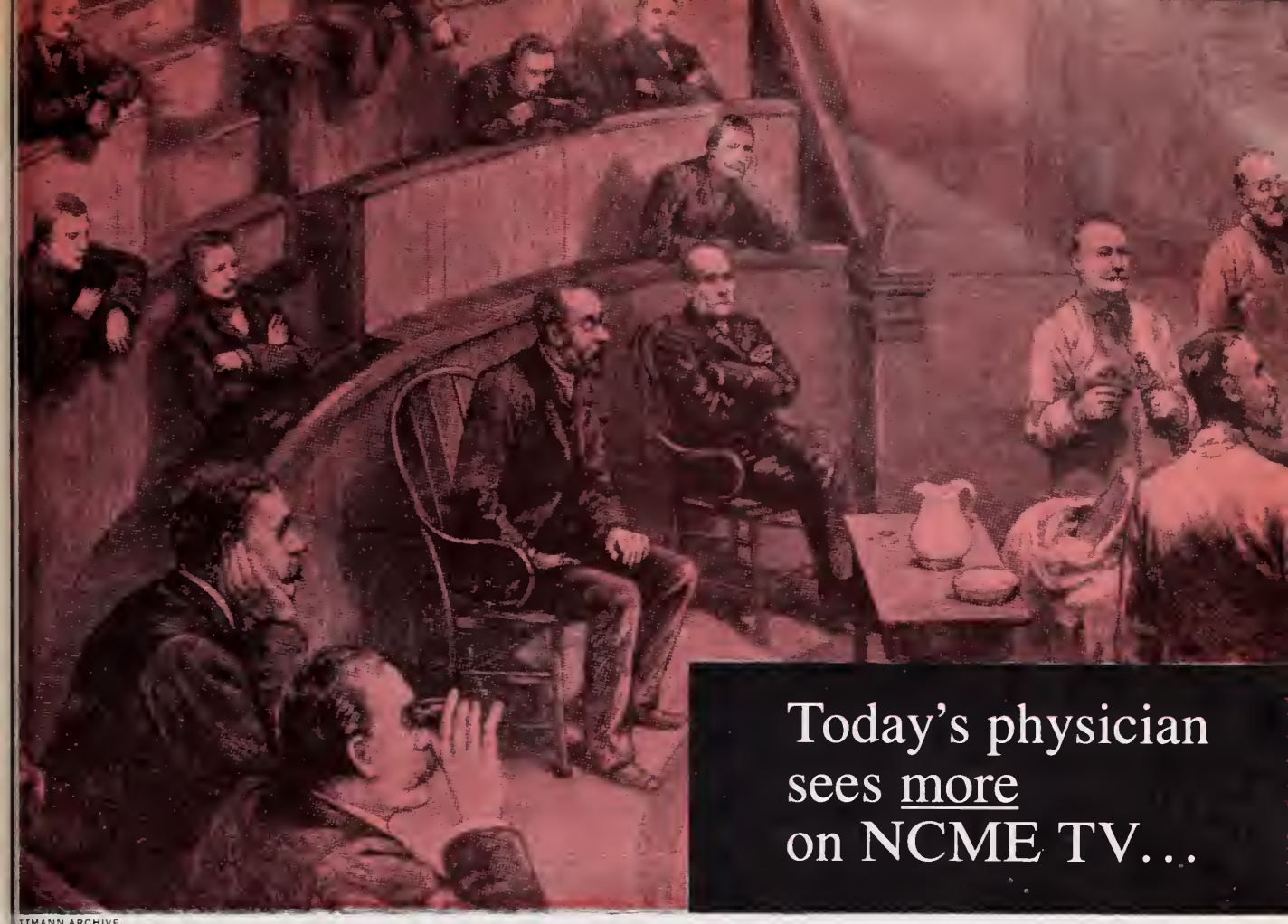
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

350-8



Today's physician sees more on NCME TV...

TTMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017


ORRY
FEAR
09209
GENERAL HOSPITAL
bills
U. S. TREASURY DEPARTMENT
INTERNAL REVENUE SERVICE
OFFICIAL BUSINESS
Bonds
worries

When life's pressures build up blood pressure

in the hypertensive patient

She's 60 and she's worried—worried about coping with life's pressures and frustrations at her age and worried about her hypertension. Learning to live with hypertension won't be easy for her, but you can prescribe assistance in the form of HYDROPRES® to help control emotional fluctuations of blood pressure.

HYDROPRES, a combination of two proven antihypertensive agents, has a mild tranquilizing effect that lets the patient relax as it reduces blood pressure. It helps alleviate symptoms associated with hypertension, such as headache and tachycardia, that frequently reflect the general tenseness of the patient.

It's worth noting that potassium loss with HYDROPRES at usual therapeutic doses is usually minimal, and a diet rich in potassium normally avoids serious depletion.

Another point to remember: When other antihypertensive drugs are used adjunctively they must be given at one half their usual dosage simply because HYDROPRES potentiates the action of such agents. HYDROPRES is contraindicated in anuria and in patients known to be sensitive to hydrochlorothiazide or reserpine.

So, when life's pressures build up blood pressure, consider HYDROPRES to help your hypertensive patient feel more relaxed while under pressure.

HYDROPRES®

ANTIHYPERTENSIVE

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRES-50:
50 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

helps your patient relax as it lowers her blood pressure

For additional prescribing information, please see following page.

INDICATIONS: Mild to severe hypertension.

CONTRAINDICATIONS: Anuria; increasing azotemia and oliguria during treatment of severe progressive renal disease. Known sensitivity to hydrochlorothiazide or reserpine. Active peptic ulcer and ulcerative colitis. Nursing mothers. If drug is essential, patient should stop nursing. Active mental depression, especially with suicidal tendencies. Electroshock therapy; discontinue drug at least 7 days before initiating electroshock therapy.

WARNINGS: May precipitate or increase azotemia. Use special caution in impaired renal function. Minor alterations of fluid and electrolyte balance may precipitate coma in hepatic cirrhosis. Dosage of other antihypertensive drugs, especially ganglion blockers, must be reduced by at least 50 percent because HYDROPRES potentiates their action. A further reduction in dosage or even discontinuation of the other antihypertensive drugs may be necessary as blood pressure falls. Stenosis and ulceration of the small bowel causing obstruction, hemorrhage, and perforation have been reported with the use of enteric-coated potassium tablets, either alone or with nonenteric-coated thiazides. Surgery frequently required and deaths have occurred. Such formulations should be used only when indicated and when dietary supplementation is impractical. Discontinue immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occurs.
Consider possibility of sensitivity reactions in patients with history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported for sulfonamide derivatives (including thiazides) and reserpine. Discontinue at first sign of depression. Nasal congestion, lethargy, depressed Moro reflex, and bradycardia may appear in infants born of reserpine-treated mothers. Thiazides cross placenta and appear in cord blood. In women of childbearing age, potential benefits must be weighed against possible hazards to fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: Hydrochlorothiazide: Check for signs of fluid and electrolyte imbalance, particularly if vomiting is excessive, or patient is receiving parenteral fluids. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant steroid or ACTH therapy, or with inadequate electrolyte intake. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Hypochloremic alkalosis occurs infrequently and is rarely severe. If dietary salt is unduly restricted, especially during hot weather, in severely edematous patients with congestive failure or renal disease, a low salt syndrome may occur. Hypokalemia may be avoided or treated by use of potassium chloride or giving foods with a high potassium content. Similarly, any chloride deficit may be corrected by use of ammonium chloride (except in patients with hepatic disease) and largely prevented by a near normal salt intake. Thiazides may increase responsiveness to tubocurarine. The antihypertensive effect of the drug may be enhanced in the postsympathectomy patient. Arterial responsiveness to norepinephrine is decreased, necessitating care in surgical patients. Discontinue drug 48 hours before elective surgery. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Use cautiously in hyperuricemic or gouty patients; gout may be precipitated. Insulin requirements in diabetics may be altered. May produce hyperglycemia and glycosuria in latent diabetics. **Reserpine:** Since reserpine may increase gastric secretion and motility, it should be used cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones, or bronchial asthma in susceptible patients. May cause hypotension, including orthostatic hypotension. Since significant hypotension and bradycardia may develop during anesthesia, discontinue two weeks prior to surgery. For emergency surgery, vagal blocking agents parenterally may be needed. Anxiety, depression, or psychosis may develop. Preexisting depression may be aggravated. Discontinue at first sign of mental depression. Use with extreme caution in patients with history of mental depression, noting possibility of suicide. Use caution when treating hypertensive patients with renal insufficiency, as they adjust poorly to lowered blood pressure levels. Use cautiously with digitalis and quinidine; cardiac arrhythmias have occurred with reserpine preparations.

ADVERSE REACTIONS: Hydrochlorothiazide: Rare reactions include thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia, jaundice. Nausea, vomiting, diarrhea, dizziness, vertigo, and paresthesias may occur. Purpura, rash, urticaria, photosensitivity, or other hypersensitivity reactions have been reported. Also, cutaneous vasculitis in elderly patients on repeated and continuing exposure to several drugs. Scattered instances of pancreatitis, xanthopsia, neonatal thrombocytopenia, and neonatal jaundice have been reported. With moderate or severe reactions, thiazide dosage should be reduced or therapy withdrawn. **Reserpine:** Reactions most often reported include excessive sedation, nightmares,

helps your patient relax as it lowers her blood pressure



nasal congestion, conjunctival injection, enhanced susceptibility to
muscular aches, headache, dizziness, dyspnea, anorexia, naus
creased intestinal motility, diarrhea, weight gain, dryness of
blurred vision, flushing of skin, pruritus. Skin rash, dysuria, syncop
puerperal lactation, impotence or decreased libido, increased sal
vomiting, bradycardia, mental depression, nervousness, para
anxiety, epistaxis, purpura due to thrombocytopenia, angina pe
other direct cardiac effects (e.g., premature ventricular contra
fluid retention, congestive failure), and CNS sensitization manifes
dull sensorium, deafness, glaucoma, uveitis, and optic atrophy ha
been noted. A Parkinson's disease-like syndrome, usually reversib
decreased dosage or discontinuance of therapy, has been observe
cautiously in hypertensive patients with coexistent coronary
disease to avoid precipitous drop in blood pressure.

**For more detailed information consult your Merck Sharp and Dohme
sentative or see the package circular.**

HYDROPRE

ANTIHYPERTENSIV

HYDROPRES-25:
25 mg. hydrochlorothiazide
0.125 mg. reserpine per tablet

HYDROPRE
50 mg. hydrochloroth
0.125 mg. reserpine per

MERCK SHARP & DOHME | **where today's theory is tomorrow's ther**
Division of Merck & Co., Inc., West Point, Pa. 19486

Florida Medical | editorial

From the Editor

Franz Stewart

Star of Hope

This is a symbol of expectation, of unexpressed desires, a future, an assurance of belonging in the scheme of things. This is for all of us, whether or not we see the Star of Bethlehem.

In our weakness and in our strength we hold to our God, to our christ, our deliverer. This is for all of us whether or not we see a manger in Bethlehem or Wise Men bringing gifts.

All men can take heart, and take courage from the teachings and truths of the Nazarene whose birthday we celebrate.

The Star of Hope becomes the Star of Love! Whether we see a great teacher, a deity, or the Son of God, we all cry out, "Merry Christmas!"

"MERRY CHRISTMAS!"

Royal College of Physicians of London

Perhaps you have never been to Bledington, never walked about the village green, seen the ancient pub, really not so clean now, or passed the time of day with another stroller. Or perhaps you never stepped aside as a cow or sheep came by. The stream flows gently, and the man cutting grass along the roadside may get to the too long grass on the green before the next fortnight.

Desmond and Cynthia were working in the garden near the ancient barn with the thatched roof, still leaking, almost not at all. The couple next door were invited by for a drink before dinner. Dame Annis took tea.

Cynthia gathered six of us about the log fire (mid-September) and there we caught some of the excitement of just being in Bledington. Dr. Annis Gillie seemed really excited when she learned I had found the date of construction of the old bake shop next door.

When I visited early next day at her invitation, Peter Smith, her husband, was working in his library, the bake shop itself. Out front was a large granite marker. This pointed the way for early Britons, before the Danes, Romans, or Normans came.

What should be the role of the general practitioner? How did the College of General Practitioners begin? Sure, she was president. The queen was so remarkable, had just the right word for each one on the honors list when Annis Gillie was knighted. I did visit the College through her introduction, but perhaps more of this later.

Over the phone in London the voice was so helpful. "Oh yes, Annis Gillie wrote to me about you. Could you have lunch with me at the Royal College of Physicians?"

And so I visited the College of Physicians on invitation of the friends next door, who lived in the ancient bake shop in Bledington.

The Library of the Royal College of Physicians of London

On July 21, 1768, an anniversary this year, William Heberdeen read a paper before the College. The paper was later published. I read from the original in the library. "There is a disorder of the breast, marked by strong and peculiar symptoms . . . . and not extremely rare of which I do not recollect any mention among medical authors. The seat of it, and sense of strangling and anxiety with which it is attended, may make it not improperly be called angina pectoris."

Another important paper read before the College even earlier is kept locked, but William Harvey seems to look down at you through his portrait. Copies of the DuMoto Cordis are available.

There to read was the original paper by Fothergill, the first report of coronary disease in angina pectoris (1776).

And so whether it is Bledington, a bake shop, or the library, there is a spirit that is compelling, and it makes one breathe more deeply and with pride, to share reflected grandeur of time and truth, but humility carries the day, and awe rules, yet I will do my part however small.

Florida Medical | medicolegal

Law and Medicine

Goble D. Dean, LL.B.

Conversation is a delicate experience in which the brasses of ego must be played sotto voce. I enjoyed good talk with my friend Goble Dean, and asked him to share some of his ideas with us all.—Ed.

For too long too much emphasis has been placed upon the conflicts existing between law and medicine, and too little has been said about their logical close relationship. It is to be expected that there are and should be differences and conflicts, but these result solely from differences in training, methods of reasoning and application of effort in arriving at fundamentally the same purpose. This purpose is service to society.

The principal causes of conflict between the legal and medical professions arise from: (1) The physician is immediately concerned with healing the sick; the attorney with healing social disorder by peaceful settlement of human disputes. (2) Physicians repeatedly state that medicine is not an exact science but an art. Nevertheless, the physician has certain exact physical laws upon which to rely and to base his inductive approach to a problem. An attorney's problems are even more inexact, dealing not with a single individual but rather with the interrelating rights of several, and with broad general ever-changing principles. He has no exact physical laws to guide him and consequently must largely depend upon deductive reasoning. (3) There is a language barrier between lawyers and physicians. The English language in itself is very complex because of one word having many definitions. When these definitions are further complicated by the refined technological definitions in medicine and the broad deductive reasoning of the lawyer, then it is no surprise that conflict results. (4) The recent tremendous population explosion with its resulting legal, social, moral, physical and religious consequences has produced new and startling demands on all facets of society, but in particular upon the physician and attorney. These demands have in turn exerted pressures on the individual attorney and physician which regrettably have increased misunderstanding in proportion to the decrease of time in which to try to understand the common aim of these professions. So much for the difficulties, conflicts and problems.

Need for Effort

Let us now examine why there should be an everlasting effort for greater understanding and cooperation between law and medicine. The growth of interprofessional relationships and the necessity of this harmony of relationship already has been strongly recognized by its promulgation in the National Interprofessional Code for Physicians and Attorneys (1958) which, in its preamble, states:

> The provisions of this Code are intended as guides for physicians and attorneys in their interrelated practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct for members of the two professions, subject to the principles of medical and legal ethics and the rules of law prescribed for their individual conduct. This Code constitutes the recognition that, with the growing interrelationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association. It will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.

Similar Goals

Man is a social animal with the ability to reason. Society is ever-changing. Man, by his ability to reason, must adapt to his changing social environment. Man cannot always by himself adapt to these changes and therefore must rely upon three professional fields: law, medicine and religion. These fields, although having different approaches, nevertheless have the same desired end result: to assist and direct man in a successful adjustment to lead a productive life for society. The clergy assist man in maintaining his spiritual integrity, physicians in maintaining

his physical integrity, and lawyers in maintaining his social integrity.

Law has many definitions but essentially it is defined to be a course of conduct. It is said that all law is derivative of the natural law and that the natural law fundamentally governs all law, whether of medicine, religion or law. We see then that law, medicine and religion are said to have the same fundamental source and desired end result (52 C.J.S. 1022-1030).

History has disclosed many interesting phases of the origin of our present day law, religion and medicine, but their true origins, developments and relationships are lost in the mists of unrecorded time. Many might argue that these professions are antagonistic and bear no true relation each to the other. Isolated examples might be used to illustrate this argument. Religion used the Spanish Inquisition to stifle law and medicine. Early medicine initiated practices contrary to religious doctrine and contrary to law sometimes for personal gain, sometimes for scientific gain. Law, in its ignorance, at times hindered religious freedom and medical research. The continuing existence, importance and cooperation of these three professions over the years, overcoming such isolated obstacles, further proves their common desired end results and the necessity of co-existence.

Today our country is wracked in a turmoil of unrealistic economic and social demands involving crime, morals, finances, war, health, racial problems, inflation, to mention only a few. In the midst of this, the three professions act as a hard core of a Rule of Conduct and remain as a hopeful beacon in a stormy sea. Each profession in itself has or is suffering revolt or reform in its own ranks, but each still holds fast to that same end result—to assist and direct man in a successful adjustment to lead a productive life for society. These conflicts and problems should bring us all closer together, for to be separated now would lead only to social disaster.

Problem and Challenge

The field of medicine today is presented with a new problem and challenge resulting from organ transplantation. Florida is one of the most advanced states having provided laws and legal forms to govern the primary problems (Florida Statutes 736.08-736.18). Organ transplants are hardly new. Skin, an organ, has been transplanted for years without undue medical, moral, or legal complications. The same is true of blood. Things began to change with corneal, kidney and similar complex organ transplants and reached a climax with heart transplants. The principal question raised is, "When are you dead?" Obviously each profession has a different approach.

As organ transplants increase and are perfected, will one of the goals of medicine be achieved without conflict, i.e., transplant of the human brain? Since the brain is commonly considered the center of intelligence, ego, psyche—yes, even of the soul—what problems are conceived? In an ordinary organ transplant, the receiving living body is the donee and the deceased body the donor. In a brain transplant will the living brain containing the intelligence, ego, psyche, soul of the "deceased," be the donor or the donee? By what name will the surviving living body be called, that of the body or that of the brain? Will the body be the transplant to the brain? What rules will govern what is a "healthy" brain and a "healthy" body for such a union? Can such a transplant be mixed as to sex? What are the property rights of the body—of the brain? How would it affect marriage and family relationships? What of the laws of inheritance? Would legal rights of action in the brain or body before transplant remain with it after transplant? If we have religious, medical and legal problems from transplants today, what do we have for the future?

Certainly, we can see that today the human being as an individual social animal is faced with tremendous problems and decisions requiring spiritual, medical and legal counseling. The present and future problems in medicine, religion and law are equally complex.

The problems and conflicts between law and medicine are trivial when compared to the need of cooperation to achieve their common goal. By having essentially a common source and common end, law and medicine have by their very nature withstood the ravages of time, criticism and frustration. They will continue to serve man and society in the future by being always faithful to the Rule of Conduct.

For a further discussion and analysis of the difficulties, conflicts and problems between law and medicine, consult "Law and Medicine" by Professor William J. Curran, Harvard Law School, and "After All, Doctors Are Human" by Professor Leonard S. Powers, University of Florida Law Review, Volume 15.

▶ Mr. Dean, 66 West Flagler Street, Miami 33130.

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Florida Medical | scientific

Indications for Cardiac Pacing In Acute Myocardial Infarction

Philip Samet, M.D.

Congestive heart failure, shock and cardiac arrhythmias with rapid or slow ventricular rates are three complications of acute myocardial infarction resulting in increased mortality. The purpose of this report is to outline the role of cardiac pacing in the treatment of some of these abnormal rhythms.

Cardiac Arrhythmias

Sinus bradycardia occurs in 11% to 14% of patients with acute myocardial infarction. First and second degree atrioventricular block has been observed in 12% to 23% of patients with acute infarction and third degree or complete atrioventricular block in 2% to 8%. Complete heart block was associated with a mortality rate of 58% to 100% prior to the era of pervenous cardiac pacing. The lesser degrees of atrioventricular block are potential warnings of complete heart block and carry a high risk of ventricular standstill, ventricular tachycardia and ventricular fibrillation. Sinus bradycardia is probably also associated with ventricular asystole and the varied grades of atrioventricular block.

Since the initial report on the use of the pervenous temporary catheter electrode for the treatment of slow ventricular rates caused by complete heart block complicating acute myocardial infarction, a number of observers have employed catheter pacing under similar circumstances in preference to drug therapy with Isuprel or atropine. It must be stressed that spontaneous revision to normal sinus rhythm occurs in the majority of patients with complete heart block complicating acute myocardial infarction. For this reason the recent development of the standby or demand pacing mode is of great practical importance. In this mode of pacing, an effective pacing stimulus results only when a QRS complex is absent for a preset, predetermined interval. For example, if the demand interval is set at 60 beats minute, a pacer stimulus results if a QRS complex is absent for more than 1 second; if the demand interval is set at 30, a stimulus results if the QRS complex is absent for more than 2 seconds; if the demand interval is set at 120 per minute, a stimulus results if the QRS complex is absent for more than 0.5 seconds. Competitive stimulation between the pacer stimuli and the patient's own QRS complex is thus avoided, reducing or abolishing the possibility of repetitive ventricular rhythms (ventricular tachycardia or fibrillation) if a pacer stimulus happens to fall on the apex of a T wave during the so-called vulnerable period. The latter may readily occur if a fixed rate pacer is employed with transient complete heart block. The demand pacer

From the section of cardiology, department of internal medicine, Mount Sinai Hospital of Greater Miami, Miami Beach, and the University of Miami School of Medicine, Miami.

impulse is generally set at 2-3 times the threshold level to minimize further the possibility of repetitive ventricular firing. Demand pacers are now readily available from a number of companies. External pacing plays little part today in the therapy of complete heart block with or without the complication of acute myocardial infarction.

Catheter Passage

The technique of temporary catheter passage deserves comment. A variety of veins may be employed to afford catheter passage—the cephalic or basilic veins, the subclavian, saphenous or external jugular veins. Since the latter vessel is often utilized for permanent catheter passage, my associates and I prefer to use the median basilic veins for temporary pervenous pacing. Catheter displacement within the right ventricular chamber is not a significant problem when arms veins are employed. We usually do not employ the blind method of passage of electrode catheters. An image amplifier fluoroscope located in the cardiac catheterization laboratory is used if the patient can be moved. If the patient cannot be moved, "blind" passage with a bipolar catheter has been attempted in the past using the tip of the catheter as an exploring intracavity lead to check position; the latter approach is successful in 75% of patients in experienced hands. A portable image amplifier is now available for bedside use and obviates the necessity for blind passage in patients who cannot be moved to the catheterization laboratory. We have utilized only bipolar catheters with the tip placed either in the right ventricular outflow tract or the right ventricular apex. The thin platinum-tipped wires recently recommended by some cardiologists are not employed because of difficulty in blind passage and the danger of knot formation. On rare occasions, in emergency situations, a transthoracic wire may be utilized to permit rapid ventricular capture by direct left ventricular needle puncture and passage of the pacing wire through the needle into the left ventricle.

Atrioventricular Block

The previous discussion refers primarily to cardiac pacing in complete heart block. A few clinicians advocate initial therapy with atropine or Isuprel for second degree atrioventricular block; if these fail, cardiac pacing is utilized. We utilize initial pacer therapy as do most cardiologists. To avoid competitive rhythm, demand standby pacing is again the treatment of choice. Fixed rate pacers are especially contraindicated under these circumstances because of the danger of repetitive ventricular rhythms with ventricular fibrillation. On the other hand, first degree atrioventricular block per se (without any other arrhythmia) is not treated by cardiac pacing but is continuously, carefully monitored.

Sinus Bradycardia

Sinus bradycardia often requires pacer therapy. If the rate is between 50-60, atropine or Isuprel therapy is carefully utilized in our institution (during continuous electrocardiographic monitoring with standby facilities for rapid catheter pacer insertion if needed) since these agents may slow the ventricular rate while increasing the atrial rate. If the rate falls below 50/minute, a bipolar catheter is passed into the right atrium by techniques similar to those described and set on atrial demand pacing modes at a rate of 60-70. Since atrioventricular conduction per se is normal under these circumstances, the ventricular rate is also 60-70. If any degree of atrioventricular block is present along with sinus bradycardia, the electrode tip catheter is passed into the right ventricle for right ventricular demand pacing at a rate of 70-75. Nodal rhythm below rates of 60 is also treated by right ventricular demand pacing at rates of 70-75.

Tachycardia

The most recent development in catheter electrode pacing in acute myocardial infarction patients involves the concept of overdriving. Despite the availability of digitalis, quinidine, procainamide, xylocaine and propranolol, some patients with episodic atrial and ventricular tachycardia continue to pose a clinical problem. The cardiac pacing catheter has been utilized both on a temporary and permanent basis to overdrive the heart (by either atrial or ventricular pacing) at rates greater than the sinus rate to prevent such ectopic rhythms. It must be emphasized that the use of the pacing catheter under these circumstances is *not* for patients with atrioventricular block but for patients with varied types of atrial and ventricular arrhythmias. The ultimate usefulness of this latter type of pacing remains to be established.

It must be stressed that rigid electrical grounding precautions are essential to prevent accidental electrocution when intracardiac electrode catheters are utilized in man.

▶ Dr. Samet, 4300 Alton Road, Miami Beach 33140.

Preliminary Experience With a New Postganglion-Blocking Agent for the Management of Hypertension

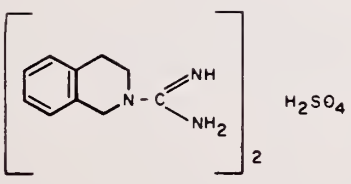
MARTIN S. BELLE, M.D., HUGH R. GILMORE, M.D., MACEY H. KEYES, M.D., AND HOWARD SANFORD, M.D.

The underlying causes of essential arterial hypertension are unknown and to date the basic disease is incorrectible. Some control over increased blood pressure can be achieved, however, by therapy aimed at reducing increased peripheral resistance and emotional stress. To this end several hypotensive agents are employed, the most powerful of which are the ganglion-blocking drugs. These tend to act additively or synergistically with other hypotensives such as the thiazides, reserpine and phenobarbital in the comprehensive treatment of the hypertensive patient. Being extremely potent drugs, however, they also give rise to numerous and sometimes serious side effects. Consequently, the search continues for newer ganglion blockers which will provide safety as well as efficacy.

In the present study we present our preliminary experience with a new, moderately potent postganglion-blocking drug — debrisoquin sulfate* (formerly isocaramidine sulfate).

Chemistry and Pharmacology

Debrisoquin sulfate is 3,4-Dihydro-2(1H)-isoquinoline carboxamidine sulfate and has the following structure:



*Declinax, Hoffmann-LaRoche Inc., Nutley, N. J.

Like guanethidine and bretylium, debrisoquin sulfate is a postganglionic vasodepressor, but its mechanism of action differs significantly from these two compounds.[1,2] It appears predominately to cause a reduction in arteriolar tone and does not deplete catecholamines stored in sympathetically innervated organs. Moreover, it blocks the release of stored catecholamines by guanethidine, presumably by either preventing the entrance of guanethidine into storage sites or blocking the spontaneous release of stored catecholamines. When administered parenterally to human subjects, it exerts pressor action with a positive inotropic effect on the myocardium for the first one to four hours; this is followed by hypotension for an additional four or more hours, but without decreased ventricular contractility below pre-drug levels.[1] When administered orally in usual therapeutic dosage, it produces hypotensive effects only.[3,4] With both forms of administration, maximal hypotensive effects are observed in the orthostatic rather than in the supine position.[3]

Initial clinical studies by other workers seem to point to debrisoquin's efficacy and practicality as an adjunctive drug in the overall treatment of hypotensive patients.[4-10] The more distressing side effects noted with ganglion-blocking agents, such as bladder atony, visual disturbances and depression, have not been reported with debrisoquin, and those reactions which have occurred have been relatively mild and easily controlled by adjustment of dosage.

Materials and Methods

In approaching the problem of arterial hypertension and its management, several questions arise concerning the upper limits of normal pressure, the level of elevation at which therapy

should be instituted and the degree of reduction which should be sought. Since there is no agreement on these questions, the arbitrary classifications as shown in table 1 were used in diagnosing the severity of hypertension and in evaluating the response to treatment. As can be seen, only diastolic pressures were considered in these classifications since reduction of diastolic pressure is a major goal.

Thirty-six patients were selected as likely candidates for treatment and were placed on a placebo for four weeks. All previously had undergone unsuccessful treatment with guanethidine or pargyline and were being seen at the hypertension clinic of the Jackson Memorial Hospital in Miami. During the period of placebo treatment, the patients were seen at weekly intervals and records were kept of their blood pressure (recumbent and erect) to establish a baseline by which future response readings could be evaluated. At the end of four weeks, ten patients were dropped from the study either because they could not return for weekly follow-ups or because markedly labile pressure determinations would have interfered with subsequent evaluation of treatment. In this way each patient acted as his own control.

The 26 patients who comprised the final study group included nine men and 17 women, ages 37 to 77 years, with an average age of 56. On the basis of their blood pressures (supine), 16 of these had severe hypertension, eight moderate and two mild. Debrisoquin sulfate was administered in initial doses of 10 mg. per day with weekly increments of 10 mg. until a satisfactory response was obtained or side effects occurred. By the end of the study period the overall range was from 30 mg. to 140 mg. per day. If the daily dosage was 40 mg. or less it was given as one dose in the morning; if it was over 40 mg. it was given in divided doses at 12-hour intervals. Concomitant hypotensive therapy included chlorothiazide alone in five patients, chlorothiazide in combination with methyldopa in four, in combination with reserpine in eight, in combination with phenobarbital in six, in combination with phenobarbital and methyldopa in one and in combination with reserpine and methyldopa in one; one patient received only phenobarbital and reserpine.

The patients were followed at the clinic for from three to six months. Prior to beginning debrisoquin therapy, each underwent a series of laboratory tests including urinalysis, complete blood counts and serum glutamic oxaloacetic transaminase (SGOT), blood urea nitrogen (BUN) and alkaline phosphatase determinations. These tests were repeated at monthly intervals. Also, to avoid unduly influencing the patients, they were not told what side effects might occur, but they were encouraged to speak freely at each visit about any reactions they may have experienced. Every effort was made to have each patient see the same doctor at each visit.

Results

As far as the standing diastolic blood pressure

Table 1.—Classification Used in Diagnosing Severity of Hypertension

Diagnostic Classification		
Diastolic pressure		
Supine	92-109 mm. Hg	Mild
	110-119 mm. Hg	Moderate
	120 and above	Severe
Evaluation of Results		
Diastolic pressure		
Supine and standing	Under 100 mm. Hg	Excellent
Supine	Under 110 mm. Hg in severe cases	Good
Supine	100 in moderate cases	Good
Supine	A fall of 10 mm. Hg *but*	
	Over 110 in severe cases	Fair
	Over 100 in moderate cases	Fair
	Over 92 in mild cases	Fair
Failure to meet these criteria *or* intolerable side effects		Poor

Table 2.—Results of Treatment with Debrisoquin Sulfate in 26 Patients with Benign Hypertension

Results	No.	Side Effects	Previous Hypotensive Agents	Concomitant Hypotensive Agent	
Excellent	7	3	7	Chlorothiazide	2
				Methyldopa	1
				Reserpine	3
Good	6	3	6	Chlorothiazide	1
				Methyldopa	2
				Reserpine	2
Fair	7	4	5	Chlorothiazide	3
				Methyldopa	2
				Reserpine	3
Poor	6	3	6	Chlorothiazide	3
				Methyldopa	1
				Reserpine	2

determinations were concerned, the results were highly satisfactory in all but one patient; on the basis of the criteria in table 1 they were excellent in seven, good in six, fair in seven and poor in six (table 2). Of the six who had a poor response, one had a satisfactory drop in blood pressure but only at dosages which produced intolerable side effects including drowsiness, constipation and failure of ejaculation. The other five patients who had poor results also had good initial drops in pressures, but they showed increasing tachyphylaxis and by the end of the study their blood pressure readings differed slightly from what they had been during placebo treatment. Some tachyphylaxis was seen initially in five patients with fair response and five who had good response; diastolic pressures again fell with increased dosage. Whether these lower pressures would have persisted over longer periods could not be established in this short time.

With the exception of the one patient previously mentioned, the only reactions noted were due to orthostatic hypotension. This occurred in 12 patients and was characterized by mild weakness or dizziness while in the standing position and was relieved by adjustment of dosages to a lower level. However, in two of the patients, lowering the dosage led to slight increases in blood pressure. Laboratory data were normal for the blood counts and urinalyses in all the patients.

Discussion

Any drug that impairs sympathetic transmission is likely to cause some degree of hypotension. The severity of this effect will depend on the individual patient and will vary from one patient to another. The development of postural hypotension, however, very often is related directly to the change in recumbent blood pressure, so that the greater the fall in supine blood pressure the greater the risk of postural hypotension. This was borne out in the current study. All the patients who experienced postural hypotension did so when their supine blood pressures dropped by 20 mm. Hg or more. Two other factors which may have played a role in the development of this side effect were the concomitant use of more than one hypotensive agent, particularly chlorothiazide, and too rapid an increase in dosages.

The second problem encountered with this group of patients was tachyphylaxis. At times, drug tolerance can be attributed to the progressive nature of the underlying disease, but in the present study this did not appear to be the case. The 15 patients who showed some degree of tachyphylaxis had benign hypertension and it was unlikely that they would have undergone such rapid regression during such a short period of observation (three to six months). Again, the concomitant use of several hypotensive drugs may have had a significant effect on the development of tachyphylaxis. More prolonged and controlled studies should be carried out with debrisoquin sulfate to prove whether or not this is the case. More studies also are warranted to determine fully the adequate dosage range, suitable dosage increases and the effects of combination with other hypotensives on the incidence of side effects.

Summary

Debrisoquin sulfate was administered to 26 hypertensive patients including nine men and 17

women ranging in age from 37 to 77 years. The dosage scheduled ranged from 30 mg. to 140 mg. per day for from three to six months. Concurrent therapy included chlorothiazide, methyldopa, reserpine and phenobarbital.

The results were excellent in seven, good in six, fair in seven and poor in six. Side effects necessitated discontinuance of treatment in one patient, and 12 others experienced postural hypotension which was controlled by reducing the daily intake of debrisoquin sulfate. Tachyphylaxis occurred in 15 patients and was responsible for the poor results in five of them. It could not be determined whether postural hypotension and tachyphylaxis were attributable to debrisoquin sulfate only or whether they resulted from the concurrent use of several hypotensive agents. Laboratory data were within normal limits.

Further studies should be carried out with debrisoquin sulfate to establish fully the adequate dosage range, suitable dosage increments and the effects in combination with other hypotensives on the incidence of side effects, tachyphylaxis and changes in body functions.

References

1. Moe, R.A.; Bates, H.M.; Palkoski, Z.M., and Banziger, R.: Cardiovascular Effects of 3,4-dihydro-2(1H) Isoquinoline Carboxamidine (Declinax), Curr. Ther. Res. 6:299-318 (Apr.) 1964.
2. Abrams, W.B.; Pocelinko, R.; Moe, R.A.; Bates, H.; Hanauer, L., and Camacho, S.: The Clinical Pharmacology of Postganglionic Sympathetic Blocking Agents, Dis. Chest 48:178-186 (Aug.) 1965.
3. Abrams, W.B.; Moe, R.A.; Bates, H.; Wallen, M.; Odez, M.; Crews, A., and Pocelinko, R.: Adrenergic Mechanisms in the Treatment of Essential Hypertension, Am. J. Cardiol. 12:711-720 (Nov.) 1963.
4. Kakaviatos, N.; Tuckman, J.; Chupkovich, V., and Finnerty, F.A.: Pressor and Depressor Properties of Ro 5-3307/1 (Declinax), Am. J. Cardiol. 13:111 (Jan.) 1964.
5. Abrams, W.B.; Pocelinko, R.; Klausner, M.; Hanauer, L., and Whitman, E.H.: Clinical Pharmacological Studies With Debrisoquin Sulfate, a New Antihypertensive Agent, J. New Drugs 4:268-283 (Sept.-Oct.) 1964.
6. Buzzi, A.: Tratamiento de la hipertension arterial con el Ro 5-3307. Med Panamer 23: 61 (Apr.) 1965.
7. Hurowitz, B.D.; Abrams, W.B., and Pocelinko, R.: Preliminary Report on Ro 5-3307/1, a New Antihypertensive Agent, Newark Beth Israel J. 14:192 (July) 1963.
8. Luria, M.H. and Freis, E.D.: Treatment of Hypertension With Debrisoquin Sulfate (Declinax), Curr. Ther. Res. 7: 289-296 (May) 1965.
9. Pocelinko, R., and Abrams, W.B.: Hemodynamic and Renal Studies With Isocaramidine Sulfate, J. Newark City Hosp. 1: 57 (July) 1964.
10. Questa, U., and Coppo, L.T.: Resultados terapeuticos obtenidos con el empleo de un nuevo agente hipotensor, el Ro 5-3307 (Declinax), Semana Med Buenos Aires 126:513 (Mar.) 1965.

▶ Dr. Belle, 1431 North Bayshore Drive, Miami 33132.

Mental Health in the Public Schools
A Psychiatrist's View

Samuel I. Greenberg, M.D.

The crucial role of the public schools in the prevention of mental illness is recognized by psychiatrists and all other behavioral scientists.[1-3] Problems with which the American family can no longer cope are falling to the public schools in ever-increasing numbers. Several generations back, when families were more stable, children had greater opportunity to identify with their parents and learn from them; however, in some families today both parents spend much time away from home. The only discipline many children receive is that provided by the schools. Futhermore, because of the inadequacy of mental health facilities of all types, many disturbed children have nowhere else to go, except to the public schools. There is no reason to believe that these conditions are likely to improve soon; they probably will get worse.

Analytically oriented psychiatrists in private practice treat relatively small numbers of patients, but since therapy is intensive, even the data from a small sample may be very significant. My patients have included students, teachers and school administrators and, in the course of treating them, I found certain patterns of neurosis to be quite common. This report is based on these observations.

At this point, it may be useful to review the fundamental dynamics of neurosis. In my opinion, it consists of anxiety and the defenses against anxiety. These defenses operate unconsciously, for the most part, and include repression, denial and projection. Anxiety in the school concerns ridicule, humiliation and being exposed as inadequate or inferior. It is heightened by overemphasis on grades, results of examinations and performing according to rigid standards, adversely affecting students, teachers and school administrators. I shall try to illustrate this with excerpts from several case histories.

Dr. Greenberg is clinical assistant professor, department of psychiatry, University of Miami School of Medicine, Miami.
Presented at the 94th Annual Meeting, Florida Medical Association, Hollywood Beach, May 10, 1968.

Clinical Histories

Case 1.—This is a 17-year-old boy, a senior in high school, who is terrified of examinations. Each time one approaches he verges on panic; he crams furiously far into the night. He is sure that he will fail; yet each time he gets a good grade. This happens repeatedly; he cannot seem to learn that he is a good student.

This excessive reaction to what is, in reality, a slight danger is based on an impoverished self-concept or low self-esteem. This is an anxiety reaction enhanced by the emphasis placed upon performance and grades. It leads to a painful style of cramming and forgetting, rather than to an orderly process of learning.

Case 2.—This patient majored in elementary education in college and when she reached her senior year was assigned to a class for practice teaching. The class was very large with many poorly motivated students from impoverished homes. They were often unruly and each day she was apprehensive that the principal or her supervisor would come in and find that she had lost control of the class. She was never relaxed and spontaneous, never able to concentrate fully on teaching. The anxiety concerning the impression she would make on her supervisor impaired her effectiveness as a teacher.

Anxiety concerning performance is not limited to students; it also affects teachers.

Case 3.—Some years ago, one of my patients was a junior high school principal in his mid-thirties. The opening day of school for the past 12 years had been one of torture for him. He was an intelligent, hard-working perfectionist who had achieved an excellent record in the school system. The school was a large one with almost 100 teachers and over 2,000 students. As the instructional leader, he expected that he should quickly and efficiently handle any problem brought to him by any of the teachers, students or parents. He was constantly fearful that one day he would slip and make some horrible mistake for all to see. He suffered from recurring depressions and agarophobia.

Case 4.—This teacher came for psychotherapy concerning a family problem which in no way impaired her effectiveness in the classroom. She had insurance which covered 50% of all medical expenses, but she would not file a claim for my services. She was afraid that in some way information would get back to her school that she was getting psychiatric help. At considerable hardship, she paid the entire cost of the treatment.

This is not an isolated instance; many teachers feel the same way. It illustrates the degree of anxiety which exists in many schools. On the

basis of almost 20 years of psychiatric experience, I would say that schools have little to fear from teachers who seek psychiatric help; however, they have much to fear from those disturbed teachers who deny their illness and refuse help.

Case 5.—When the patient was in the third grade, her teacher locked her in the clothes closet for the entire day because of some minor infraction. It is now 25 years later and the patient still has claustrophobia. This was an unusual incident; however, most psychiatrists have encountered similar ones.

While this phobia cannot be blamed entirely on the incident with the teacher, neither would I minimize the enormous harm done to the patient by that one action. Children are as vulnerable to the actions of their teachers as they are to the actions of their parents. The psychological damage that a severely disturbed teacher can inflict on 30 children in the course of a school year is staggering. In my opinion, school administrators are very slow to recognize and control dangerously disturbed teachers. They tend to avoid facing these problems realistically; they do not want to "rock the boat." The mechanism of denial protects the image of the school, the facade that all is orderly and calm.

Case 6.—One of my patients is a man in his early thirties who has been plagued by severe anxiety reactions for many years. Soon after his six-year-old daughter started in first grade, he noticed that she was very anxious about getting to school on time. When he questioned her, she first denied that anything was wrong but then confided in him. Her great fear was that she would not be in her classroom when the tardy bell rang and that she would be sent to the principal's office. She was not sure what would happen there, but the thought of it was terrifying. My patient then said to his daughter something like this: "Try to be on time for school, but don't worry so much about being late. Nothing bad will happen to you in the principal's office nor anywhere else in the school. The teachers are there to help you learn. The purpose of ringing the bell is to let the teachers know when to start their classes." Soon after this talk, her anxiety subsided and she became more comfortable about going to school.

By recognizing the problem early, allowing her to ventilate and by re-education, this parent probably stopped a phobia from developing. This was not only good for her mental health but also her educational progress. In my opinion, she will learn more as a result of the diminution of the anxiety.

Comment

Based on observations of patients in private practice, it is my opinion that an undesirably high level of anxiety exists in the public schools. Students are afraid of teachers, teachers of principals and parents are afraid of both. Many parents are afraid to speak freely to teachers about their children for fear of provoking the teachers' hostility which they may then "take out on the children." In the early grades, teachers tend to frighten pupils; in the later grades, the reverse is often true. In the long run, intimidation is good neither for education nor mental health. While teachers and parents may get quick results with threats and intimidation, I agree with Bettelheim that this is the worst way to teach.[4]

The most widespread anxiety in the public schools, and the greatest obstacle to education, is the fear of getting poor grades or failing examinations. This leads to many defenses, conscious and unconscious, against these humiliating experiences. Students avoid difficult courses and those teachers who have the reputation of failing many students. They do not ask questions in class for fear of appearing stupid. It is obvious how these measures interfere with learning. Recently, so many students at a leading university were avoiding the courses of a distinguished teacher because he gave low grades that his courses had to be made required ones, but ungraded.

Self-esteem is painfully low in the neurotic. To study hard and then get a poor grade is a crushing blow to students. This psychological disaster must be avoided. They project the blame for their poor performance on teachers or the school administration. They rationalize that they will never need or use the courses, or that the subject matter is dull. The neurotic pattern is self-defeating. The more difficult the course and the greater the chance of failure, the more compelling it is not to study. The healthy student meets this problem realistically; if the course is difficult, he studies harder. One psychiatrist has said, adolescents operate on the principle of "nothing ventured, nothing lost," of course, much of it unconsciously. The student is only aware of the fact that he cannot develop any interest in the course or concentrate upon it. Parents are quick to call it laziness; more often it is an inhibition that stems from a fear of failure and a loss of self-esteem.

In my opinion, the most valuable thing a school can do for the student is to encourage him to try. If he does not succeed, he can learn from the experience. The most valuable lessons often are learned from our own mistakes. In

too many schools, the student is not encouraged to make mistakes. There is too much emphasis on performing and conforming to rigid standards. The emphasis should be on trying, learning and growing; it will stand the student in good stead for the rest of his life. The goals of education and the promotion of mental health are identical.

The word educate means "to lead forth." In my opinion, education consists of providing the leadership and the materials so that the creative energies of the student may develop. In the words of Robert Browning, it is "opening out a way for the imprisoned splendor to escape." The purpose of education is not merely to produce technicians but to develop self-respecting, clear-thinking citizens. A good teacher stimulates curiosity and imparts the feeling that learning is an adventure, that it can be fun. Just as important as the subjects taught is the manner in which they are taught. Students will identify with and copy some of the characteristics of those teachers they respect. Often the best teaching is done by setting an example.

Respect for the dignity and worth of each student serves both the goals of education and mental health. While I should like to see less anxiety in the schools, and less intimidation, I do not advocate disrespect for proper authority. Absence of intimidation does not mean chaos. There is a difference between discipline and punishment: the former means the teaching of limits which is valuable; the latter means to hurt or damage.

While I have pointed out some deficiencies in the public schools, let me also point out that I feel, on the whole, they do an excellent job under difficult circumstances. Classes are too large and equipment is often inadequate. There are children in the public schools who properly belong in residential treatment centers or mental hospitals. Because these facilities are woefully inadequate, they have nowhere else to go and the public schools struggle valiantly with them.[5] They take up an enormous amount of the time and energy of school personnel and interfere with the education of the other students. The great majority of teachers are capable and dedicated. They make a vital contribution to the mental health of the community. In the course of her professional career, the elementary school teacher will have a decisive influence on almost 1,000 impressionable young people. Good teachers cannot be paid enough; poor ones we cannot afford at any salary.

Second only to the home, public schools provide the greatest opportunity to teach children those character traits and values which are necessary for mental health. Prevention is much less costly than treatment. The cost of mental illness is staggering; recently it has been estimated at $20 billion annually for the entire country.[6] In Florida, the cost of maintaining a patient in a state mental hospital is approximately $7 a day or $2,500 per year. Many patients will require hospitalization for 10 to 20 years at a cost of $25,000 to $50,000. There will never be enough money for everything that the state needs, but to economize at the expense of the schools is the poorest way to save money. Money denied the schools will cost the state many times that amount in the treatment of mental illness and in crime. The public schools provide the greatest opportunity in the prevention of mental illness.

Summary

More and more problems are falling to the public schools as the American family becomes less effective in educating and disciplining its children. Many disturbed children are in public schools because mental health facilities are woefully inadequate.

Based on observations in private psychiatric practice, certain neurotic reactions were found to be common among students, teachers and school administrators. High levels of anxiety concerning grades, failing examinations and conforming to rigid standards are harmful to mental health, as well as to education. Excerpts from clinical histories are presented to illustrate these points.

The goals of education and the promotion of mental health are similiar. The public schools provide the greatest opportunity to stimulate effective procedures in the prevention of mental illness.

References

1. Allinsmith, W. and Goethals, G. W.: The Role of Schools in Mental Health. New York, Basic Books, 1962.
2. Richmond, J. B. and Covert, C.: Mental Health and Education Conference, Arch. Gen. Psychiat. 17:513, 1967.
3. Millar, T. P.: Psychiatric Consultation with Classroom Teachers, J. Am. Acad. Child Psychiat. 5:134, 1966.
4. Bettelheim, B.: Dialogues with Mothers. New York, The Free Press of Glencoe, 1962.
5. Stickney, S. B.: Schools Are Our Community Mental Health Centers, Am. J. Psychiat. 124:1407, 1968.
6. Conley, R. W.; Comwell, M., and Arrill, M. B.: An Approach to Measuring the Cost of Mental Illness Am. J. Psychiat. 124:755, 1967.

▶ Dr. Greenberg, 418 Dupont Plaza Center, Miami 33131.

Failure and Frustration
A Tale of Clinical Research

Asa L. Godbey Jr., M.D., and Richard I. Hendra, M.D.

Working in a U.S. Navy dispensary, we grew fat and happy. The procedure was fantastically routine and easy. There were five of us at the time, all waiting to complete our service obligations before returning to pre-arranged civilian residencies. We had organized our own self-teaching program. This was a rotating series of lectures and demonstrations designed to provide a good medical review and teach us clinical skills. We were highly competitive, and prided ourselves in the fact that our intradispensary competitiveness kept us on our toes and we think provided excellent medical care.

Retreat

It was in this setting that our diagnostic acumen came under fire. One of our aviators was denied a job with a major airline because of diabetes mellitus! With a good deal of skepticism we rationalized that he had not had proper dietary preparation before the airline's medical department had administered the routine three-hour glucose tolerance test. Our random urine sample just six months before had proved negative. We loaded the man with 300 grams of carbohydrates per day for three days, then repeated the oral glucose tolerance test. He had diabetes mellitus, but his fasting urine was negative for glucose.

We retreated to lick our wounds. Why, it was intuitively obvious to the casual observer that any mild diabetic individual could have a glucose-negative urine in the fasting state. It was painful to realize that almost all our 0700 physical exams would naturally be performed on fasting individuals. Who in his right mind would get up early to eat breakfast before an annual physical exam, particularly when the skipper would be expecting him to lose half a day's work anyway, and so would allow him time to eat breakfast after the exam? Indeed, in reviewing our records we found that no new cases of diabetes mellitus had been uncovered in the preceding 4,000 physical examinations at our dispensary.

Advance

We decided to evaluate our program and to institute changes. Our laboratory was equipped to handle only routine work. We checked urines for glucose, but were unable to perform blood chemistries. The local hospital laboratory could perform these, but only in limited numbers. Routine glucose tolerance tests or postprandial blood glucose determinations were "out." We thought of purchasing the necessary glucose to provide an oral load for each man prior to urinalysis, but with our budget the cost was prohibitive. Nonetheless, the idea struck our fancy. We contacted the galley and they agreed to supply, free of charge, all the chocolate milk we wanted. That was "it." One pint of chocolate milk contains 53 grams of carbohydrate. This would be a palatable volume of liquid, and an acceptable load of carbohydrate for our purposes.

Our screening procedure was set. We would collect a "random" urine sample from each examinee for routine and microscopic evaluation, utilizing glucose oxidase reagent strips for glucose detection. The examinee then would be required to consume the one pint of chocolate milk before proceeding through the complete physical evaluation including dental, optometric, audiometric, electrocardiographic, roentgenographic and phys-

The opinions or conclusions contained in this report are those of the authors and do not necessarily reflect the views or endorsement of the Navy Department.

Dr. Godbey is a resident, department of psychiatry, William A. Shands Teaching Hospital and Clinics, University of Florida College of Medicine, Gainesville. He was formerly lieutenant commander, Medical Corps, United States Navy.

Dr. Hendra is a resident, department of medicine, Henry Ford Hospital, Detroit. He was formerly lieutenant, Medical Corps, United States Naval Reserve.

ical examinations during which a one-hour postprandial urine sample would be collected and tested for glucose.

At this point we became overwhelmed by grandiose ideas. Would this not be an excellent chance to "research" a new and easily applicable tool for mass diabetic screening? A quick perusal of the literature confirmed that the most efficient method of screening for diabetes includes a determination of the individual's blood sugar,[1] but we reasoned that many communities would have neither the funds nor the facilities for mass screening using this method. Post-load urine samples have been shown to be of more value in mass screening than random samples,[2] and it has also been shown that test meals chosen by the individual tend to yield lower blood sugar values than those obtained by controlled carbohydrate intake.[3] We felt we had something to offer. All we had to do was try it.

Objective Accomplished

A total of 1,090 healthy, asymptomatic males ranging in age from 17 to 39 years were evaluated. Of these, only one spilled glucose in the "random" sample. This subject and 26 others were noted to spill glucose during the postprandial screening procedure and subsequently underwent three-hour oral glucose tolerance tests utilizing test doses of 100 grams of glucose. These were performed after three days of dietary loading with at least 300 grams of carbohydrate. Each venous whole blood sample was analyzed at the hospital laboratory by the auto-analyzer method, and each urine sample was examined for glucose utilizing glucose oxidase reagent strips.

We evaluated the results of the glucose tolerance tests by applying the American Diabetes Association's criteria. A total of 24 individuals were found to have abnormal results from glucose tolerance tests (table 1). Of these, 10 had diabetes mellitus or "probable" diabetes mellitus. Five demonstrated ill-defined disorders of glucose intolerance other than diabetes mellitus. Another group of nine subjects exhibited a lowered renal threshold for glucose. Of these, one man spilled glucose in all urine samples and another was found to have persistent microscopic hematuria, believed due to chronic glomerulonephritis after complete urological evaluation including renal biopsy. Two subjects responded normally to the glucose tolerance tests, demonstrating a normal glucose tolerance curve with no glycosuria. We believed there had been glycosuria at the time of the screening procedure due to low carbohydrate intake. Presumably this effect was overcome by controlled carbohydrate loading prior to glucose tolerance testing.[4] One subject found to spill urinary glucose at the time of the screening procedure was lost to follow-up.

Evaluation

We were ecstatic! Then, after reflection, the awful truth reared its ugly head. Yes, a great

Table 1.—Results of Glucose Tolerance Testing

Category	Glucose Tolerance Testing Criteria	Number of Patients
Diabetes Mellitus	Peak blood glucose > 160 mg% 2-hour blood glucose > 120 mg% Glycosuria with hyperglycemia	4
Probable Diabetes Mellitus	Peak blood glucose > 160 mg% 2-hour blood glucose 110-120 mg% Glycosuria with hyperglycemia	6
Glucose Intolerance	Peak blood glucose > 160 mg% 2-hour blood glucose < 110 mg% Glycosuria with hyperglycemia	5
Low Renal Threshold	Peak blood glucose < 160 mg% 2-hour blood glucose < 110 mg% Glycosuria with fasting blood glucose levels	9
Normal	Peak blood glucose < 160 mg% 2-hour blood glucose < 110 mg% No glycosuria	2

deal of work had gone into the project, but we had not proven a thing. We had failed to test a cross-sectional group of the non-glycosuric subjects and, therefore, could not really prove the efficacy of the method as a screening tool for diabetes mellitus. We could imply the method was a good one but could only demonstrate from these results that it was superior to random sampling, which is a well known fact. By the time this came to light we had resumed civilian status and could not go back to patch up the hole in our procedure.

After the initial period of despair, with its host of attempted rationalizations, we accepted the finality of the situation. We had not accomplished our purpose, but our efforts were not totally wasted. Over a thousand individuals had received rather complete physical evaluations, and several of them could now be carefully followed through government facilities for "service connected" biochemical aberrations. A new approach to mass diabetic screening now presented itself—one that could be utilized by any community with available medical or paramedical personnel and the benevolent cooperation of a local dairy. Lastly, and possibly most importantly, two eager young physicians had tasted the bitter fruit of their own slightly misdirected labors, and would forever be aware of the need for common sense scientific planning prior to the initiation of a "clinical research" project.

> Failure is, in a sense, the highway to success, inasmuch as every discovery of what is false leads us to seek earnestly after what is true, and every fresh experience points out some form of error which we shall afterward carefully avoid.
> KEATS

Summary

A total of 1,090 healthy, asymptomatic males ranging in age from 17 to 39 years were screened for glucose intolerance by testing a one-hour postprandial urine sample for glucose. A 53 gram carbohydrate load in the form of one pint of chocolate milk was used as the screening challenge. All "positives" were given three-hour oral glucose tolerance tests after three days of carbohydrate loading. Though the purpose had been to prove the efficacy of this procedure in screening for diabetes mellitus, the "experimental design" was such that only the superiority of the postprandial urine sample over the random sample could be demonstrated.

References

1. Packer, H.; Hawkes, J. M., and Ackerman, R. F.: A Comparison of Urine and Blood Tests in Diabetes Detection, Diabetes 10:280-285 (July-Aug.) 1961.
2. Remein, Q., and Wilkerson, H. L.: The Efficiency of Screening Tests for Diabetes, J. Chronic Dis. 13:6-21 (Jan.) 1961.
3. West, K. M., et al: Oral Carbohydrate Tolerance Test, Arch. Int. Med. 113:641-648 (May) 1964.
4. Conn, J. W.: Interpretation of the Glucose Tolerance Test: The Necessity For a Standard Preparatory Diet, Am. J. Med. Sci. 199:555 (1940).

Dr. Godbey, 1615 Northwest 21st Street, Gainesville 32601.

Comparative Studies With 0.025% Fluocinolone Acetonide Cream and 0.2% Fluocinolone Acetonide Cream

Richard S. Flatt, M.D.

The present medical literature abounds with reports of the effectiveness of topically applied anti-inflammatory steroids for the control or management of various dermatological problems. Unfortunately, there are many patients who do not respond to the currently available steroid preparations. The need for an evaluation of a more concentrated topical steroid, namely fluocinolone acetonide 0.2%, apparently represents such an improvement over the presently available therapy and is the basis of this study.

The effects of currently available fluocinolone acetonide 0.025% are abundantly reported in the literature.[1-3] Fluocinolone acetonide is structurally identical to triamcinolone acetonide except for the introduction of a second fluorine atom at the six alpha position in ring B. These two fluorine atoms can be concluded to be responsible for the enhanced topical potency of this steroid.[4]

Material and Methods

A double blind study was undertaken incorporating select patients exhibiting bilateral lesions. Fluocinolone acetonide 0.025% was used on one lesion as a control and the experimental fluocinolone acetonide 0.2% was used on the other paired lesion. The experimental fluocinolone acetonide 0.2% is eight times more concentrated than the preparation which then was available. All cases were equally involved bilaterally and involvement was limited enough so that 15 gm. of each material would suffice for one week of application.

Each patient received unlabeled tubes containing fluocinolone acetonide 0.2% and fluocinolone acetonide 0.025%. The patients were instructed to apply each cream thinly to symmetrical areas with occlusion under Blenderm tape or Saran Wrap once a day, or up to four times a day topically. During 1965 and 1966, 105 patients were treated. The responses were graded upon clinical grounds by the examiner and the symptomatic responses were judged by the patient. The dermatoses investigated are outlined in Table I.

Table 1

Disease Treated	Total Cases
Contact dermatitis	44
Psoriasis	15
Eczematous dermatitis	10
Atopic dermatitis	7
Neurodermatitis	7
Dyshidrotic eczema	5
Stasis dermatitis	2
Discoid lupus erythematosus	2
Granuloma annulare	2
Herpes simplex	2
Intertrigo	1
Rhus dermatitis	1
Nummular dermatitis	1
Seborrheic dermatitis	1
Pemphigus foliaceus	1
Pompholyx	1
Rosacea	1
Ant bites	1
Mosquito bites	1

Presented at the 11th Annual Meeting, Noah Worcester Dermatological Society, Jan. 7-13, 1968, Runaway Bay, Jamaica.

Results

In 5% of the cases, there was no improvement with either preparation. This included two cases of psoriasis, one case of granuloma annulare and two cases of severe contact dermatitis.

The lesions on 35% of the patients cleared in equal time. This took anywhere from three days to 12 weeks of therapy.

Of the total, 25% of the patients cleared one week sooner with the 0.2% cream; that is, if it took four weeks to clear the lesion using the standard 0.025% cream, it took three weeks to clear with the experimental 0.2% fluocinolone acetonide cream.

Another 25% of the patients cleared in half the time with the fluocinolone acetonide 0.2%; thus, if it took two weeks for the 0.025% cream to clear the condition, it took only one week for the experimental 0.2% cream to do likewise.

In 10% of the patients, clearing with the 0.2% fluocinolone acetonide cream was quite dramatic, while the 0.025% cream did not produce any improvement.

The patients whose lesions showed a dramatic improvement when treated with the higher concentration of fluocinolone acetonide were afflicted as follows:

One case of herpes simplex—the other case showed no improvement.

One case of granuloma annulare—it was interesting to note that the other case of granuloma annulare showed no improvement with either preparation. Both cases were treated under occlusive dressings.

One case of otitis externa of seven years duration, which previously had been controlled only by injecting steroids, completely cleared with the 0.2% fluocinolone acetonide cream.

One case of discoid lupus erythematosus (DLE) of the scalp which previously was controlled only by steroid injections did remarkably well with the 0.2% fluocinolone acetonide cream.

One case of DLE cleared under occlusive dressings with the 0.2% fluocinolone acetonide cream. No improvement had been noted in the past when using 0.025% fluocinolone acetonide cream under occlusive dressing.

Thin plaque-type lesions were completely cleared in three cases of psoriasis under occlusive treatment. A paper evaluating the entire 15 cases of psoriasis included in this study will appear shortly in Cutis magazine.

Three cases of pruritus ani not controlled by 0.025% fluocinolone acetonide cream in the past and only controlled by repeated localized injections of steroids were cleared with 0.2% Synalar cream.

No adverse or systemic reactions were noted upon completion of this evaluation in any of the 105 cases treated.

Summary and Conclusion

Fluocinolone acetonide 0.2% was subjected to a double blind comparative study with fluocinolone acetonide 0.025% on 105 patients exhibiting various bilateral dermatoses. It was found that the 0.2% fluocinolone acetonide cream is a potent preparation. When lower strength steroid preparations fail, the increased concentration fluocinolone acetonide can be used with some degree of predictable success. More rapid results were achieved with the fluocinolone acetonide 0.2% cream in 60% of the 95% of patients whose lesions cleared.

The results achieved in treating DLE, granuloma annulare and herpes simplex, even though incidence was small, merit further investigation.

The fluocinolone acetonide 0.2% cream has been found to be valuable in recalcitrant cases of pruritus ani, otitis externa, dermatoses of the eyelids and areas where it is difficult to obtain an increased concentration of steroid through the barrier layer by the usual means of local injection of steroids. This treatment also has been valuable in treating patients who cannot tolerate pain, children and psychiatric cases.

Acknowledgement

Fluocinolone acetonide 0.2% and fluocinolone acetonide 0.025% was supplied as Synalar HP and Synalar 0.025% Cream, respectively, by Syntex Laboratories, Inc., Palo Alto, Calif.

References

1. Robinson, H. M. Jr.: Fluocinolone Acetonide, Arch. Derm. 83:149 (Jan.) 1961.
2. Cahn, M. M. and Levy, E. J.: Fluocinolone Acetonide, A New Topical Corticosteroid: Clinical and Pharmacological Evaluation, J. New Drugs 1:202 (Nov.-Dec.) 1961.
3. Samitz, M. H.: Clinical Evaluation of Topical Fluocinolone Cream, Curr. Ther. Res. 4:12 (Dec.) 1962.
4. Feldman, I.: Improved Dermatological Therapy with Fluocinolone Acetonide, A New Topical Steroid, J. Am. Osteopathic Assn. 63:257-260, 1963.

Dr. Flatt, 1950 Arlington Street, Sarasota 33579.

editorial comment

JOSEPH FARRINGTON, M.D

For the past 15 years, the major class of compounds utilized in the treatment of inflammatory diseases has been the corticoids. Initially, the naturally occurring adrenocorticoids were available only in small quantities and were expensive. Efforts were directed toward more efficient production of cortisone, or hydrocortisone. In 1953 and 1954 Fried and Sabo[1,2] described the synthesis of A α-chloro and 9 α-fluoro hydrocortisone, respectively. These steroids were found to be more potent than the natural adrenocorticoids, and this finding led to the rapid synthesis of even more potent anti-inflammatory agents. Increased potency, however, was not the sole result of molecular manipulation. Biological activities of the derivatives were somewhat altered from those inherent in hydrocortisone, and certain chemical groups were found responsible for specific pharmacological effects. Some of these effects were not always desirable. Major unwanted properties of anti-inflammatory corticoids are the antianabolic or catabolic activity, sodium retention and potassium excretion, as well as the effect on carbohydrate metabolism as reflected by hyperglycemia. The goal was not only to tailor the steroids for anti-inflammatory potency but to eliminate the undesirable activities.

Laboratory assay procedures have been useful in establishing potencies of corticoids for several pharmacological properties. A widely used assay of anti-inflammatory activity is based upon the inhibition of granuloma formation around implanted cotton pellets. Inhibition is directly related to anti-inflammatory potency. Another popular test procedure is based upon the property of corticoids to cause involution of the thymus. Perhaps the most universal assay for corticoid activity is that of liver glycogen deposition. Animal tests help to measure results of chemists' labor to increase the anti-inflammatory potency and to disassociate it from undesirable effects, but only through clinical trials and experience with humans can the corticoids settle into their proper sphere of usefulness. As shown elsewhere in this journal, corticosteroids deposited in the right place in the skin will result in improvement of certain dermatoses. The question still remains as to how this deposition best can be accomplished. Intralesional injections, topical application with or without plastic film dressings, jet sprays and so forth have their disadvantages. An ever-expanding series indicates that topically applied corticosteroids are absorbed in significant amounts when applied to diseased skin. Almost one-fifth of the amount applied was excreted in the urine of one patient.[3] Virtually no information has come to our attention concerning the amount excreted in the feces, sweat, tears, sebum and keratin. All these and other possible routes of excretion of topically applied corticosteroids need study if we are to understand the true magnitude.

Car and Wieland[4] confirm that adrenal suppression takes place after occlusive treatment of whole-body areas with newer anti-inflammatory corticosteroids. They also confirm this suppression is transient and the adrenals recover rapidly (within 48 hours). With occlusive dressings, cutaneous atrophy has been encountered in certain body regions, particularly genitocrural areas. The dangers of viral encephalitis by topical application of steroid preparations in herpes and chicken pox perhaps have been exaggerated.

Topically, the compounds presently available, including Flumethasone, may be considered safe and therapeutically effective under normal clinical conditions.

References

1. Fried and Sabo: J. Am. Chem. Soc. 75:2273, 1953.
2. Fried and Sabo: J. Am. Chem. Soc. 76:1455, 1954.
3. Butler, J.: Brit. J. Derm. 78:665-668 (Dec.) 1966.
4. Car and Wieland: Arch. Derm. 96:269-272 (Sept.) 1967.

▶ Dr. Farrington, 567 Florida National Bank Building, Jacksonville 32202.

Papilledema
Its Relationship to State of Responsiveness in Chronic Subdural Hematoma

Albert W. Auld, M.D., Donald M. Dooley, M.D.
and Irwin Perlmutter, M.D.

Alteration of the state of awareness is one of the most important signs of chronic subdural hematoma.[1] In our series of 70 patients with chronic subdural hematoma, some degree of alteration in state of responsiveness was present in 63 (90%). These patients were classified as lethargic, stuporous or comatose. Seven patients (10%) were alert and oriented but complained of headache; an interesting observation has been noted among them. Although only seven of the 70 patients developed papilledema, four of those with papilledema were among the seven who were alert and oriented.

Report of Cases

Case 1.—This 50-year-old man sustained a head injury two weeks prior to admission to the hospital. He complained of progressively more severe headaches and nausea and vomiting. He noted numbness of the left arm and hand intermittently. He was alert and oriented without focal neurological signs; bilateral severe papilledema was present. A chronic subdural hematoma was removed from the right side and the patient made a complete and uneventful recovery.

Case 2.—This 26-year-old woman, with no known head injury, complained of progressively more severe frontal headaches, dizziness, and weakness of the left arm and leg, which had been present for two weeks. Examination revealed an alert and oriented woman whose principal complaint was frontal headaches. She had bilateral papilledema and mild weakness of extremities on the left side. She made an uneventful recovery after removal of a large, right-sided subdural hematoma.

Case 3.—This 51-year-old man presented with progessive left occipital headaches of three weeks' duration. He had a mild head injury six weeks prior to admission but had been alert and oriented until two days before admission. Numbness and weakness of extremities on the right side had developed. Bilateral early papilledema was present and he had become partially aphasic hours before the removal of a left chronic subdural hematoma. The patient made an uneventful recovery with the exception of some difficulty with speech.

Case 4.—This 65-year-old white woman sustained a head injury three weeks prior to admission with progressive frontal headaches, increasing lethargy and confusion, and finally stupor. Examination revealed bilateral papilledema and a Babinski sign present on the right. A chronic left subdural hematoma was removed surgically and she made an uneventful recovery.

Case 5.—This 42-year-old woman presented with lethargy, weakness and progressively decreasing state of awareness of two weeks' duration; bilateral papilledema but no other neurological signs were present. A right-sided subdural hematoma was removed at surgery and she made an uneventful recovery.

Case 6.—This 54-year-old man presented with a three week history of occipital headaches. Two days prior to admission he became stuporous and restless. A right Babinski sign was present and also bilateral papilledema. At surgery a chronic subdural hematoma was removed from the left side and he made an uneventful recovery.

Case 7.—This 50-year-old man had suffered a head injury three weeks prior to admission to the hospital, sustaining a left frontal linear skull fracture at that time. Progressively more severe headaches slowly developed. He was alert and oriented at all times until he became partially aphasic. Bilateral papilledema was present. A large subdural hematoma was removed from the left side; recovery was uneventful except for some mild speech disturbance. He was re-admitted to the hospital several weeks later for recurrence of subdural hematoma which was evacuated, and again did well.

Summary and Discussion

Seventy consecutive patients with chronic subdural hematoma were reviewed. Of the seven patients who developed papilledema, four were alert and oriented. Since, of seven alert patients in this series of 70, four were among those having papilledema, a relationship appears to exist between state of awareness and papilledema in patients with chronic hematomas.

Papilledema has been noted to be an unusual finding in elderly patients with chronic subdural hematomas.[2] A common presenting sign in patients with subdural hematomas is depressed state of awareness. This is also true in this series. A positive relationship between papilledema and alertness and between normal fundi and depressed state of awareness appears to exist in patients with chronic subdural hematomas.

The development of papilledema in an alert and mentally clear patient complaining of headache is not an unusual occurrence with chronic subdural hematoma,[3] and the gradual deterioration of the state of responsiveness in a patient without papilledema may also herald the presence of a chronic subdural hematoma.

References

1. McKissock, W.; Richardsen, A. and Bloom, W. H.: Subdural Hematoma; Review of 389 Cases, Lancet 1:1365-1369 (June 25) 1960.
2. Perlmutter, I.: Subdural Hematoma In Older Patients, J.A.M.A. 176:212-214 (Apr. 22) 1961.
3. Behrman, Simon: Pathology of Papilledema, Brain 89:1-14, 1966.

From the department of surgery, University of Miami School of Medicine, Miami.

▶ Dr. Auld, 4685 Ponce de Leon Boulevard, Coral Gables 33146.

the antacid puzzle

In peptic ulcer:



solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

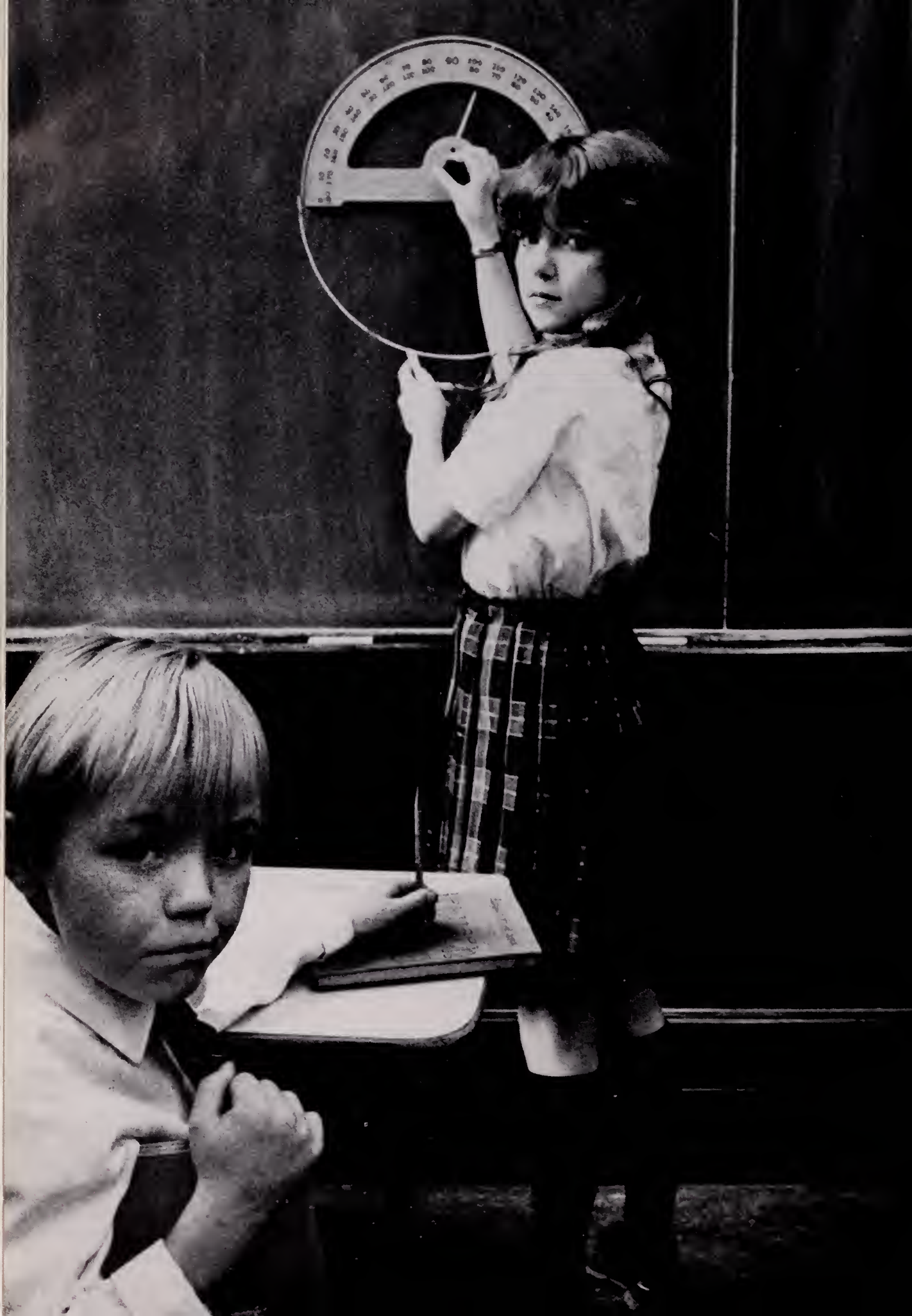
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW



pinworms in this school?

possibly, because hygienic measures alone, however meticulous, may not prevent the spread of pinworm infections which are estimated to occur in from ⅓ to more than ½ of all American children from every social level

REMINDER: Because pinworm infections spread easily and quickly in families, schools, and institutions, multiple infections among primary groups seem to be the rule rather than the exception. For successful management, it is desirable to check all exposed members of the family or play group. The *single-dose efficacy* of POVAN makes therapy entirely practical, convenient, and economical.

INDICATION: Pinworm infection.

PRECAUTIONS: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be colored red.

ADVERSE REACTIONS: Nausea, vomiting, cramping, and diarrhea have been reported.

POVAN is available in suspension or tablet form. The pleasant-tasting, strawberry-flavored suspension contains the pamoate equivalent of 10 mg. of pyrvinium base per cc., in 2-oz. bottles. The sugar-coated tablets each contain the pamoate equivalent of 50 mg. of pyrvinium base, bottles of 25.

When examination reveals pinworm infection—an increasing number of physicians favor treatment with a single, well-tolerated dose of—

Povan®
(pyrvinium pamoate)

PARKE, DAVIS & COMPANY, DETROIT, MICHIGAN 48232

PARKE-DAVIS

44768

The Mellon Mission in Haiti

Everett Shocket, M.D.

Each dawn there emerges from the Haitian palm jungle straw-hatted, graceful black men and women on foot, on horse, on donkey, converging on the Albert Schweitzer Hospital, and thus each new day is a fresh fulfillment of an idea as romantic as Don Quixote, but as practical as an intrauterine device.

The 100-bed ranch-style hospital was built by dreamer-realist William Larrimer Mellon, grandnephew of Andrew Mellon, Pittsburgh steel magnate, who at the age of 37 abandoned his life as a gentleman-rancher in Arizona and turned toward missionary medicine. While studying at Tulane he corresponded with his spiritual mentor, Albert Schweitzer, and searched for a suitable mission site. In 1958, 90 miles from the Haitian capital of Port-au-Prince, his hospital opened.

From the Albert Schweitzer Hospital to Port-au-Prince it is five hours by auto in the dry season when each passing vehicle leaves a choking wake of dust that obscures the road for minutes and soils the lush roadside greenery, and in the rainy season it is even longer, for the pot-hole accumulations of cascading water simply preclude passage.

Culture and Diseases

Beyond the hospital walls, peasants toil at subsistence farming. They live in loosely aligned wood and rough cement structures with no inside toilets. An adjacent lean-to with a leafy covering gives protection for outdoor cooking, eating and socializing (fig. 1). Family life is matriarchal: casual man-woman alliances are formed and disbanded with shifting instability. The culture is a melange of the African and Latin American. It is African in its love of good humor, in the physical grace and dignity of handsome women in gay print smocks balancing huge burdens on their statuesque heads, and it is African as the drums mournfully beckon under the night sky. It is Latin American in the rhythm of its music—syncopated and swaying—and its proliferation of straw hats worn by both men and women.

Ninety per cent of these Haitians are Catholic, but 100% practice voodoo. The voodoo is an expression of inner spiritualism; it resolves fears and permits escape from the grinding misery of daily reality. Its night drum beat with grotesque



Fig. 1. — Preparing "meal."

human shadows gyrating around a jungle fire and the sipping of liquor provide fulfillment for a simple disadvantaged peasantry. In its psychedelic frenzy, many find release. Some step not close to the fire, but into it, and become burn victims.

In December, 1966, working briefly in this exciting medical oasis planted by Dr. and Madame Mellon, I noted that Dr. Mellon wisely excluded maternity patients from the hospital. If he had not, the total facilities would be fully absorbed by the community's petite population explosion. A prenatal clinic is conducted with an emphasis on tetanus vaccination of each expectant mother and, thus, the passive protection of the expected newborn, too. In the jungle, neonatal tetanus abounds. Cords are severed by field machetes and coated with various earthy emollients to ward off evil. There are enough neonates with tetanus to keep a 30-bassinet ward filled constantly (fig. 2).



Fig. 2.—Neonatal tetanus nursery.

Malnutrition in weanlings is also widespread enough to necessitate a separate 30-crib ward and often two youngsters in a crib (fig. 3). Bloated with hypoproteinemic edema, the childrens' overlying skin is dry and coarse and thus vulnerable to refractory ulceration. Their black hair is fragmented at the tips, producing a russet halo, symptomatic of kwashiorkor which means "red boy" in the West African tongue, Ashanti. The malnourished child is usually the penultimate youngster who is too young to fend for himself at the communal table, and yet too old for the special attention of the mother who is in turn nursing her latest.

After tetanus and kwashiorkor, the most common clinical entity is ubiquitous tuberculosis which presents as scrofula in neck-swollen chil-



Fig. 3. — Malnourished youngsters with dry coarse skin, swollen abdomens, sallow eyes, leg ulcers and russet-tinged hair.

dren, as Pott's disease in bowed adults and as classical unapparent pulmonary disease. Occasionally the patient presents with tuberculous peritonitis. Five years ago a 25-bed unit was established a half-mile from the main hospital. With its own vegetable garden, this long-term jungle sanitorium is run by dedicated Canadian nuns.

Clinic Days

Mondays, Wednesdays and Fridays are outpatient clinic days and some 350 peasants trek miles to be treated. With customary Mellon perception, a mixture of idealism and of sensitiveness to the pride of the people, the hospital requests two gourds (40¢) per visit. By sundown some of these 350 patients have been hospitalized while others, not quite as ill, have been laid across clinic benches or stretched out on mattresses on the clinic floor so that during the long night they can receive restorative intravenous feedings with antibiotics with the intent that they be discharged the following day. This is a stop-gap measure for ill patients for whom a hospital bed is simply not available. At sundown the healthier of the 350 patients are happily enroute home by horse, by bus or by foot. They grip their precious medicines from the hospital pharmacy (fig. 4) and they happily rub the sore arm where they received the much admired "pic-pic" injection. Denied an anticipated injection, patients leave crestfallen.

Remember that the Bocar, the voodoo healer, uses burning coal and similar gross techniques. Patients have transferred that faith to these hospital injections. Also, every H.A.S. patient receives prophylactic tetanus vaccination. This is simply a public health venture. In addition to medications in hand, they leave with an inner glow of having been kindly tended by nurses and doctors who communicate a living sense of good will each day. Further, many a poor child leaves the hospital with a gay new frock. The kindly nurses thrust the old tattered garment into an empty corner and deftly cut to size a clean, second-hand dress; all while the doctor, seemingly unnoticing, changes a dressing. By sundown, too, some of the 350 patients are just ready to leave the clinic after a full day of examination, of x-rays and medications. Finding that night has fallen, rather than wend their way through the jungle in the dark, they simply roll up on the flagstones of the hospital's entrance and await dawn. Forty or so such human blobs have to be gingerly stepped over as one walks across the front courtyard of an evening. When moonlight fails, the snoring guides.



Fig. 4. — Straw-hatted men and women at the efficient hospital pharmacy.

Medicine and Hope

H.A.S. nurses earn $150 a month. They eat in a large screened-in cafeteria sitting at long wooden tables. They are Swiss, Dutch, German, Canadian and a few Americans. They serve for two years as do the dozen doctors. Each year more and more of the professional staff is indigenous and one day it will be an all-Haitian staff.

A group of Mennonite lads work in the lab as technicians, in the pharmacy and outside the hospital compound in Dr. Mellon's community development program. Indeed, Dr. Mellon has found that if his hopes for the Valley are to be fulfilled, he must offer not only needed medical care, but also must evoke a local leap forward in agriculture and in husbandry. An irrigation project and clean water has been provided. He is at the hospital at 6:30 in the morning and shortly thereafter is out in the community building a dam, a road or whatever. In a relaxed, colored sport shirt and simple khaki trousers, he is a quiet giant whose calm exterior belies the bright light that drove him across continents and through years of intense professional training to bring his example of ethical living and humanitarianism to fruition.

Dr. Shocket, 1680 Meridian Avenue, Miami Beach 33139.

Our Mail

J.A.M.A. Editor Comments

Dear Dr. Talbott:

Under separate cover we have forwarded you copies of recent issues of the Florida Medical Journal.

Dr. Franz H. Stewart of Miami, who assumed the editorship of our journal as of the June issue, thought that you might be interested in our efforts to improve the quality of our publication and to make it a true reflection of medicine in this state.

We would be very grateful for any suggestions or comments you might have at any time. If you are interested, we would be very pleased to send you a complimentary subscription.

Whenever we might be of assistance to you or the Journal of the American Medical Association, please let us know.

Eugene L. Nixon
Managing Editor

Dear Mr. Nixon:

This is my first opportunity to respond to your letter which contains the delightful information that Franz Stewart is the new editor of your journal. I congratulate your Board of Governors on obtaining such leadership. Franz is an outstanding physician and I know will do a fine job. In regard to suggestions or comments, does Macy's tell Gimbel's? The answer is probably yes, but in this instance I can speak in general terms only. After casual review of each of the issues, it is obvious that Dr. Stewart has a fine base upon which to build. Each issue had items of unusual interest; copy was far from the throwaway type.

Editing takes hard work, imagination, and enthusiasm. If one wishes, one can take a ruler and draw a straight line graph equating quality of the final product with the several characteristics noted of the editor. I know of no secrets held by an inner circle of editors and hasten to assure you that no one has a monopoly on editorial achievements.

I predict a great future for your journal.

John H. Talbott, M.D., Editor
Journal of the American Medical Association
Chicago

August Artist

You will remember the Spanish galleon wrecked on a Florida shore on the cover of our August issue. We are grateful to Mr. Randum for this and for the other excellent illustrations he did for us in the history issue.—Ed.

I wish to apologize for my tardy response to thank you for the copies of the Florida Medical Journal which you were so kind to send me, and also in honoring my request by sending a copy to Miss Nona V. Acton, who has acknowledged receipt by a letter to me.

You may realize that I am a patient of Dr. William M. Straight; it may be some interest (editorially) that the illustrations were done under unusual circumstances—namely while I was under hospitalization.

Please consider that it will be my pleasure to offer my cooperation to the extent of my ability toward any possible future requirement. I also appreciate the fact that the illustrations were well received and am extremely pleased to note that they have lead to complimentary comment by your subscribers; for this advisory I also thank you, as it is not often that an artist is made aware that his work is appreciated in a publication. I join you in hoping that we shall have the opportunity to work together on some future project.

Newton Randum
Miami

Woman's Auxiliary

For some time now I have been wanting to write you a note to tell you how much I appreciated your invitation to the Woman's Auxiliary to participate in the July issue of the JOURNAL.

I think you are doing a grand job on the JOURNAL and I, for one, love the "new look."

Please let us know if we can ever be of any further assistance.

Eleanor B. Carson (Mrs. Russell B.)
Immediate Past President
Woman's Auxiliary to the
Florida Medical Association
Fort Lauderdale

Smoke Screen

Dear Editor:

During the past year large numbers of physicians, dentists, teachers, lawyers and other professional persons received a reprint of an article on cigarette smoking which appeared in the January 1968, issue of True magazine. Among those receiving this reprint, undoubtedly, were readers of your journal.

Very serious questions have been raised as to the accuracy, impartiality and integrity of this article and its method of distribution.

On March 21, the Wall Street Journal published an article by Ronald Kessler revealing that the reprints were sent out not by True, which was the impression given, but by Tiderock Corporation, a public relations firm employed by the Tobacco Institute.

I have entered the Wall Street Journal article into the Congressional Record, along with comments by the Public Health Service and the American Cancer Society (March 27, 1968, p. S3415 et seq). The National Interagency Council on Smoking and Health has had this reprinted and informs me that copies will be furnished free upon request to the Council, Box 3654, Central Station, Arlington, Va. 22203.

Warren G. Magnuson, Chairman
U. S. Senate Committee on Commerce
Washington, D.C.

Those of us who are involved in medicine tremendously appreciate the work that Senator Warren G. Magnuson is doing in this area. The True magazine article Senator Magnuson refers to was written by Stanley Frank, 600,000 copies of which were mailed to opinion leaders throughout the nation by the Tiderock Corporation, a public relations firm hired by the Tobacco Institute. This is a perfect example of what we are up against in this area of preventive medicine. Mr. Frank is an employee of Hill and Knowlton, Inc., a long time public relations representative for the Tobacco Institute, Inc. and the True magazine promotion was paid for by the Tobacco Institute in a roundabout way.

The article by Senator Magnuson from the Congressional Record goes into all the background in detail and covers the ramifications of Mr. Frank's article. It is very worthwhile and all of the physicians throughout the state and nation should write for a reprint of this to get some concept of the tremendous pressures being brought by the Tobacco Institute to prevent any restriction on their advertising of cigarette smoking and to try to keep the public calmed regarding the dangers of smoking.

I believe, as do many other physicians throughout the nation, that the public has not yet grasped the tremendous seriousness and frightening implications of this problem. The rate at which squamous cell carcinoma of the lung, emphysema and coronary artery disease deaths are increasing in this nation, attributable to smoking, is there for all who wish to read. Once the matter is studied, it is impossible not to be frightened by the conclusions drawn. This is one of the all-time major problems of preventive medicine in this nation.

Mr. John F. Banzhaf, the attorney who initially activated the fairness doctrine in the TV industry, did some of the initial background work to bring this duplicity to the public's attention. A suit now is pending in New York City which would compel the National Broadcasting Corporation to enforce the fairness doctrine.

How to get the true impact of this problem in front of the American people has yet to be solved. Those thousands of our fellow men throughout the nation who are trying and want to stop smoking are not helped at all when misleading articles and misstatements are presented about the lack of danger of smoking.

Senator Magnuson is to be commended for his efforts in the field of preventive medicine, particularly smoking, and it is our sincere hope that all of the physicians of the nation will support him in the endeavors to control the smoking problem.

Charles F. Tate Jr., M.D., Chairman
Florida Committee on Smoking and Health
Miami

Consolidated Thanks

The Honorable Hans Tanzler, Mayor
City of Jacksonville

Dear Mayor Tanzler:

We are very pleased to present to you the enclosed advance copy of the October issue of the Journal of the Florida Medical Association.

On pages 939 and 940 you will note an article entitled "Renaissance in Jacksonville" which commemorates the recent governmental consolidation. On page 977 we have provided a complimentary page for one of the Jacksonville Area Chamber of Commerce's advertisements.

The Florida Medical Association and its Journal are proud to be located in the city of their birth and to play a part in its life. Whenever we may be of service to you, please let us know.

Eugene L. Nixon
Managing Editor

Dear Mr. Nixon:

Thank you very much for the complimentary copy of the October Journal. It is indeed nice of you to report on our new consolidated government. We thank you greatly. With the support of community-spirited associations such as your own, we need never worry about the success of our Bold New City.

Hans G. Tanzler, Jr.
Mayor
City of Jacksonville



early relief from

DEPR



At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves . . . mood fluctuations lessen . . . sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type . . . any degree of severity.

LAKESIDE

IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects hav been encountered: dry mouth, constipation, dizz ness, palpitation, delayed urination, agitation an stimulation ("jumpiness," "nervousness," "anxiety, "insomnia"), bad taste, sensory illusion, tinnitu sweating, drowsiness, headache, hypotensio (orthostatic), flushing, nausea, cramps, weakness blurred vision and mydriasis, rash, tremor, allerg (general), altered liver function, ataxia and extra pyramidal signs, agranulocytosis.

Additional side effects more recently reporte include: seizures, eosinophilia, confusional state with hallucinations, purpura, photosensitivity, galac torrhea, gynecomastia, and impotence. Side effect which could occur (analogy to related drugs) in clude weight gain, heartburn, anorexia, and han and arm paresthesias.

DOSAGE: Optimal results are obtained at a dosag of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hydro chloride) tablets of 25 mg.; bottles of 50, 500 an 1,000; and tablets of 50 mg. in bottles of 30, 25 and 1,000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 5320

ESSION

NORPRAMIN®
(desipramine hydrochloride)

improvement often begins in 2 to 5 days



ee package insert for complete prescribing information.



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

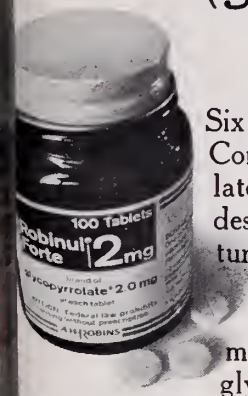
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming): Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

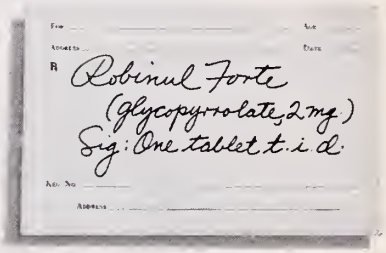
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Florida Medical meetings

FMA Approved Postgraduate Meetings

DECEMBER

6- 8 Current Concepts on Management of the Spinal Cord Injured Patient, Americana Hotel, Bal Harbour

9-11 Present Status of Orthotics and Immediate Postsurgical Prosthetic Fitting of the Amputee, Americana Hotel, Bal Harbour

JANUARY

2- 5 Teaching Family Medicine Workshop, University of Miami, Miami

9-12 Sixth Annual Postgraduate Seminar in Anesthesiology, Eden Roc Hotel, Miami Beach

15-18 Seminar in Surgery Art and Science in Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach

15-19 Bedside Interpretation of Laboratory Data, Americana Hotel, Bal Harbour

23-24 Seminar in Obstetrics and Gynecology, J. Hillis Miller Health Center, Gainesville

23-25 Third Annual Radiotherapy Symposium, Four Ambassadors Hotel, Miami

26-30 Annual Pediatric Postgraduate Course—"Renal and Genitourinary Disorders," Deauville Hotel, Miami Beach

Jan. 30-Feb. 1 Developmental Aspects of Perception, Hearing, Speech and Learning, J. Hillis Miller Health Center, Gainesville

MARCH

12-15 Teaching Conference in Clinical Cardiology, Hilton Plaza Hotel, Miami Beach

19-22 Trends in Systems for the Radiologic Examination of the Alimentary Tract, Sheraton Four Ambassadors Hotel, Miami

Mar. 31-Apr. 2 Current Trends in Chest Roentgenology, Fontainebleau Hotel, Miami Beach

National and Regional Meetings in Florida

DECEMBER

1- 4 Clinical Convention of the American Medical Association, Miami Beach

4- 6 Academy of Psychosomatic Medicine, Eden Roc Hotel, Miami Beach

9-11 Southern Surgical Association, Boca Raton Hotel and Club, Boca Raton

10-14 American Academy for Cerebral Palsy, Americana Hotel, Bal Harbour

FEBRUARY

8-13 Twenty-First Annual Seminar of the International Academy of Proctology, Hollywood Beach Hotel, Hollywood Beach.

13-15 Society of University Surgeons, Fontainebleau Hotel, Miami Beach

MARCH

2- 5 International Anesthesia Research Society, Americana Hotel, Bal Harbour

15-19 American Academy of Allergy, Americana Hotel, Bal Harbour

APRIL

28-May 1 American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour

30-May 3 Neurosurgical Society of America, Key Biscayne Hotel, Key Biscayne

MAY

2- 4 American Academy of Psychoanalysis, Deauville Hotel, Bal Harbour

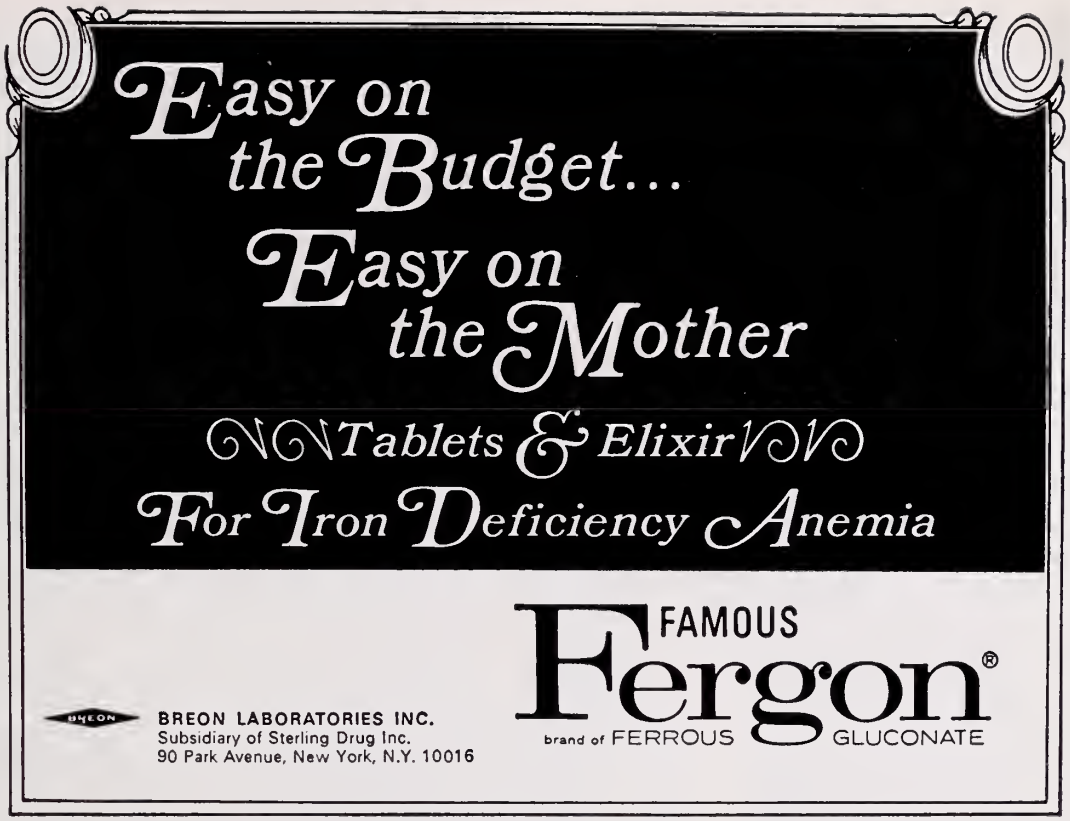
3 American College of Psychiatrists, Deauville Hotel, Bal Harbour

4- 9 American Society for Microbiology, Fontainebleau Hotel, Miami Beach

5- 9 American Psychiatric Association, Americana Hotel, Bal Harbour

22-25 National Tuberculosis and Respiratory Disease Association, Fontainebleau Hotel, Miami Beach

24-26 American Thoracic Society, Fontainebleau Hotel, Miami Beach



Announcing the Thirty-Second Annual Meeting of
THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
Conference Headquarters — Roosevelt Hotel
March 10, 11, 12, 13, 1969

GUEST SPEAKERS

Henry K. Beecher, M.D., Boston, Mass.
Anesthesiology
Norman D. Nigro, M.D., Detroit, Mich.
Colon and Rectal Surgery
Rudolf L. Baer, M.D., New York, N. Y.
Dermatology
W. H. J. Summerskill, M.D., Rochester, Minn.
Gastroenterology
Edward J. Kowalewski, M.D., Akron, Pa.
General Practice
John G. Masterson, M.D., Hines, Ill.
Gynecology
Ray W. Gifford, Jr., M.D., Cleveland, Ohio
Internal Medicine
Raymond V. Randall, M.D., Rochester, Minn.
Internal Medicine
William J. German, M.D., New Haven, Conn.
Neurosurgery
Robert A. Kinch, M.D., Montreal, Que.
Obstetrics
John R. Lynn, M.D., Dallas, Tex.
Ophthalmology
A. B. Sirbu, M.D., San Francisco, Calif.
Orthopedic Surgery
Douglas P. Bryce, M.D., Toronto, Ont.
Otorhinolaryngology
A. James French, M.D., Ann Arbor, Mich.
Pathology
Louis Gluck, M.D., Miami, Fla.
Pediatrics
Wilma C. Diner, M.D., Little Rock, Ark.
Radiology
James D. Hardy, M.D., Jackson, Miss.
Surgery
John W. Kirkland, M.D., Birmingham, Ala.
Surgery
Russell Scott, Jr., M.D., Houston, Tex.
Urology

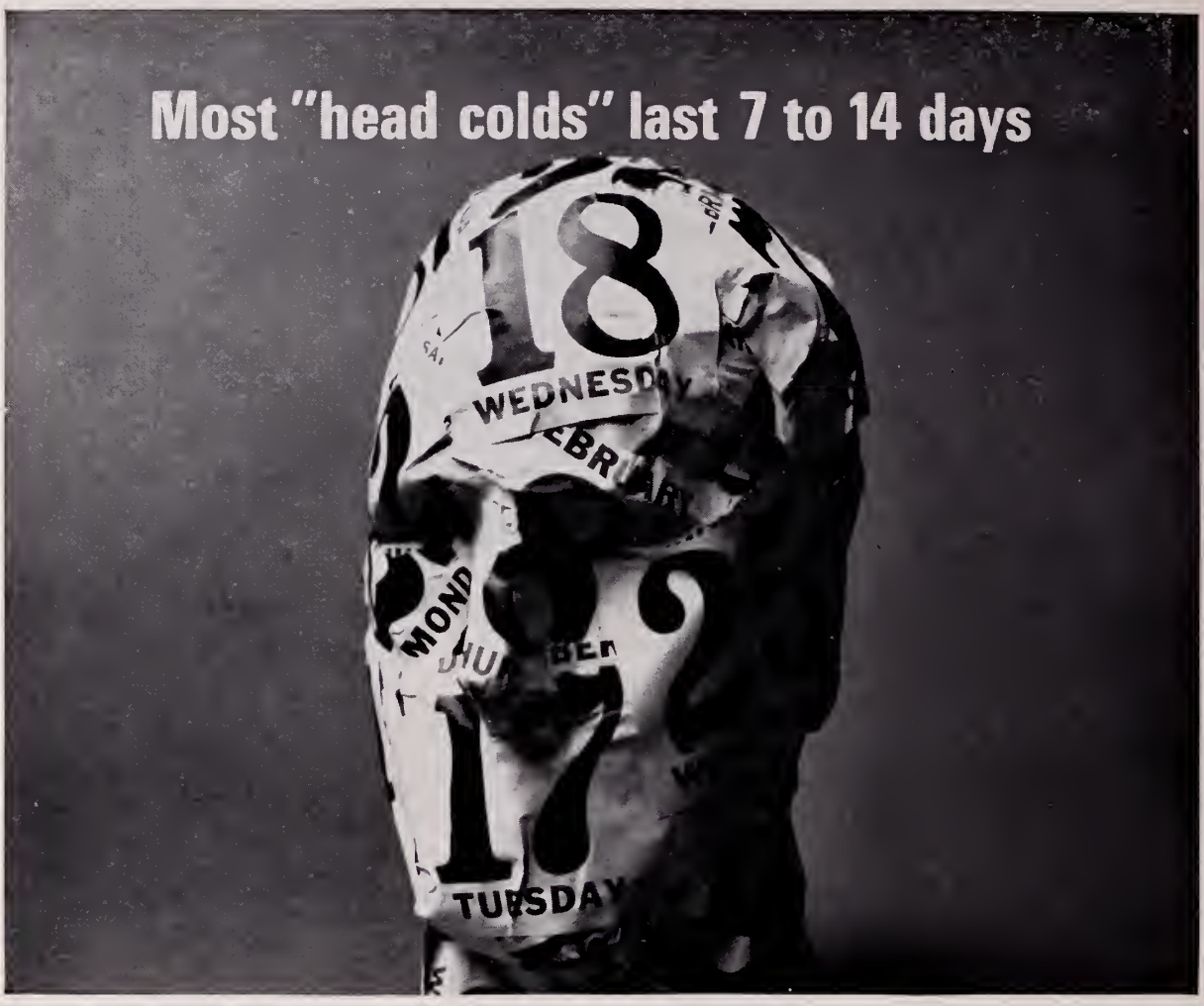
Additional speaker to be announced

Lectures, symposia, clinicopathologic conference, round-table luncheons, medical motion pictures, technical exhibits, and entertainment for visiting wives.

(All-inclusive registration fee—$30.00)

This program is acceptable for three and one-half (3½) prescribed hours and twenty-eight (28) elective hours by the American Academy of General Practice.

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.



In the meantime...Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark. Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.
Spansule® capsules brand of sustained release capsules

SK&F Smith Kline & French Laboratories

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

TAO® (triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

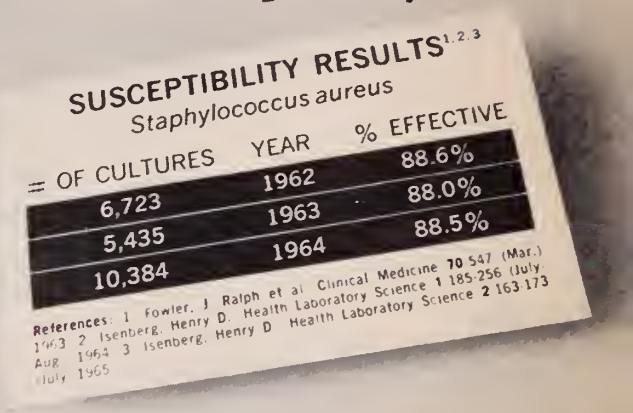
Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

Rx ROERIG

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

In vitro
susceptibility results
with TAO® (triacetyl-
oleandomycin)
in *Staphylococcus aureus* cultures,
as shown in
studies of
antibiotics.

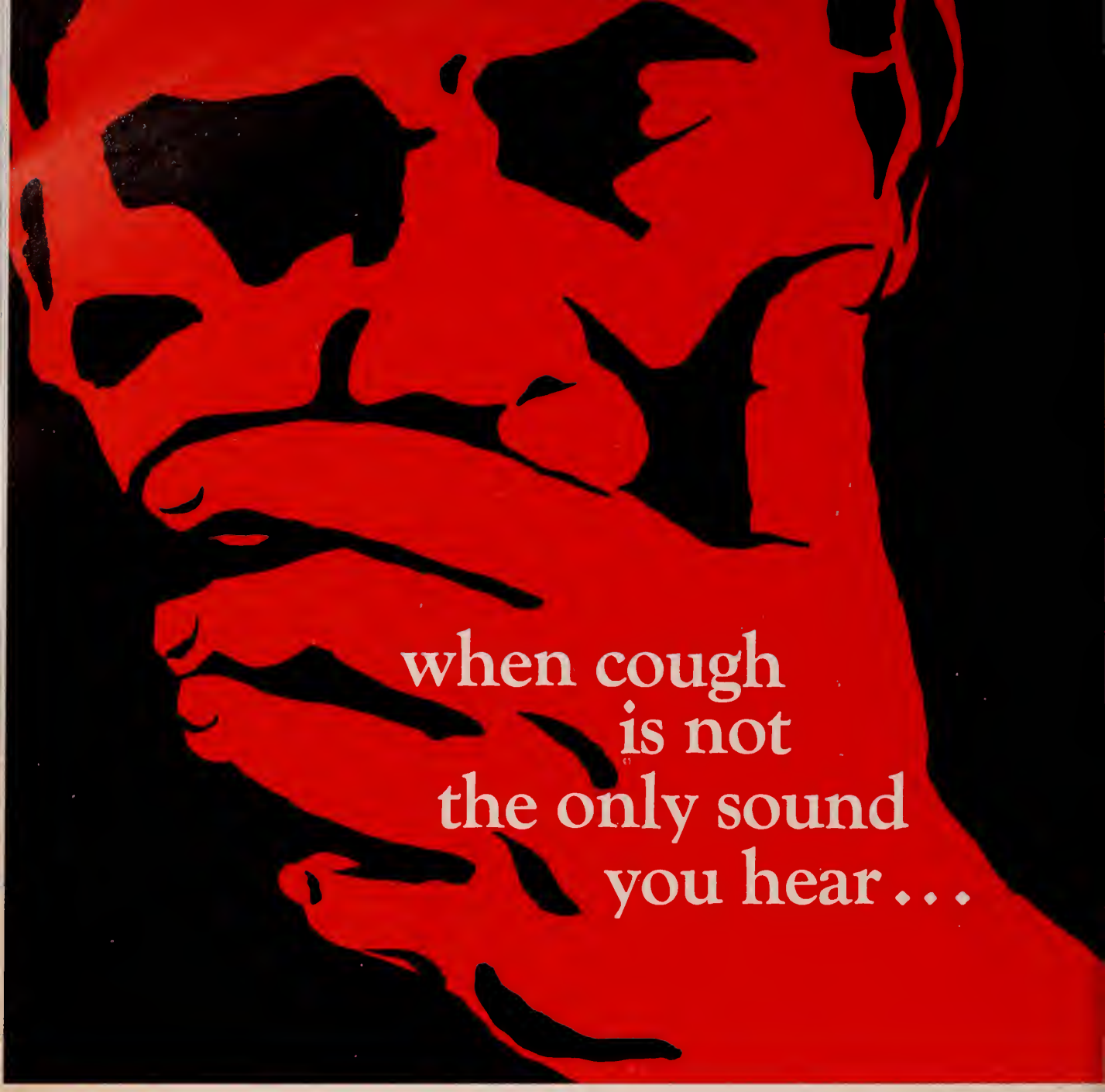

SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

= OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1 Fowler, J Ralph et al Clinical Medicine 70 547 (Mar.) 1963 2 Isenberg, Henry D. Health Laboratory Science 1 185-256 (July, Aug. 1964 3 Isenberg, Henry D Health Laboratory Science 2 163-173 July 1965

TAO® (triacetyl-
oleandomycin)
is a macrolide antibiotic, for use only in
the treatment of acute severe
infections where adequate
sensitivity testing has
demonstrated susceptibility
to this antibiotic and resistance
to other less toxic agents.





OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.



DOCTOR —

Would you like to present a scientific exhibit at the 1969 FMA Annual Meeting being held May 14-18 at the Americana Hotel, Bal Harbour?

The Committee on Scientific Assemblies is now accepting exhibit applications. Deadline for applications is January 1, 1969. An application form may be obtained by filling in your name and address below and mailing this page to Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203.

Yes, I am interested in presenting a scientific exhibit at the 1969 FMA Annual Meeting. Please send me an application form.

_____
(Name)

_____
(Address)

_____
(City)



"COCA COLA AND COKE" ARE REGISTERED TRADE MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA COLA COMPANY

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY
OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available
Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

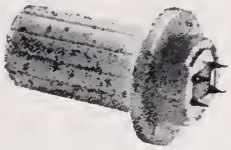
or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704 - 253-2761

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

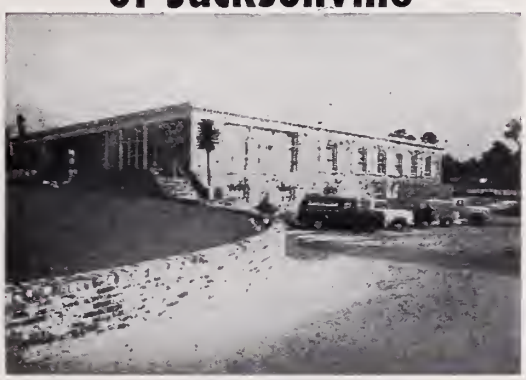
Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

YOUR Patronage Has Made Our Growth Possible

Medical Supply Company of Jacksonville



Home Office

JACKSONVILLE
4539 Beach Blvd.
Telephone FL 9-2191

ORLANDO
1511 Sligh Blvd.
Telephone GA 5-3537

A Modern Psychiatric Hospital . . .



This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

SAM J. CLARK, M.D., PRESIDENT
ALFRED PETSCHOW, ADMINISTRATOR

Staff Psychiatrists
August C. Herman, M.D.
Joseph K. Niswonger, M.D.
Wilfred C. Jorge, M.D.
Edgar B. Hodge, M.D.
Arie denBreeijen, M.D.

LAKELAND MANOR, INC.
2510 North Florida Avenue
Lakeland, Florida 33802
Telephone (813) 682-6105

Member American Hospital Association
Medicare Provider





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

A COMPLETE BUSINESS SERVICE

Professional Management

FOR THE MEDICAL AND DENTAL PROFESSIONS

PM FLORIDA

233 Fourth Ave, N.E.
St. Petersburg, Florida
Phone 898-5074

1855 Hillview Street
Sarasota, Florida
Sarasota Phone 958-4493
4771 Bilmark
Ft. Myers, Florida
Ft. Myers Phone 936-3162

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS · since 1932 PM ©

417 Executive Building
1175 N.E. 125th St.
Miami, Florida 33125
Dade Phone 751-2101
Broward Phone 523-0286

Affiliates of Black & Skaggs Associates
Battle Creek, Michigan

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 836-7201

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 43 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION . . . . . NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.
Hill Crest is fully accredited by the Joint Commission on Accreditation of Hospitals.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

Florida Medical | deaths

Ayers, Sanford Emmett, Winter Garden; born 1899; University of Louisville, 1931; member AMA; died Oct. 25, 1968, aged 69.

Bicknell, George Francis, Gainesville; born 1882; Rush Medical College, 1907; member AMA; died Aug. 7, 1968, aged 86.

Blackmon, William Parks, Eau Gallie; born 1920; LeGrange, Georgia; Emory University School of Medicine, 1945; member AMA; died Sept. 19, 1968, aged 48.

Campbell, William Rogers, Miami; born 1931; Miami, Florida; Meharry Medical College, 1957; member AMA; died Aug. 16, 1968, aged 37.

Dunaway, Carl Ellis, Miami; born 1893; Valdosta, Georgia; Emory University School of Medicine, 1916; member AMA; died Sept. 7, 1968, aged 75.

Gilmer, Eugene S., Tampa; born February 11, 1887, Talbotton, Ga.; Emory University School of Medicine, 1909; member AMA; died July 31, 1968, aged 81.

Hartman, David, Allandale; born May 25, 1905, New York City; New York Medical College, 1929; member AMA; died Aug. 3, 1968, aged 63.

McClary, George R, North Miami; born July 10, 1911, Benton, Tenn.; University of Tennessee College of Medicine, 1936; member AMA; died April 20, 1968, aged 57.

Robinson, James L. Jr., Naples; born February 20, 1907, Gastonia, N. C.; University of Pennsylvania School of Medicine, 1932; member AMA; died May 19, 1968, aged 61.

Simon, Herbert J. Hollywood; born Nov. 30, 1905, Denver, Colo.; Loyola University School of Medicine, 1930; member AMA; died July 2, 1968, aged 63.

Skilling, Francis Curie, Miami; born August 26, 1900, Chicago, Ill.; Harvard Medical School, 1930; member AMA; died Aug. 18, 1968, aged 68.

Smith, Arthur B., South Yarmouth, Massachusetts; born 1896; Mt. Vernon, Illinois; University of Tennessee College of Medicine, 1923; member AMA; died Sept. 21, 1968, aged 72.

Tocci, Frank Paul, Fort Lauderdale; born January 25, 1914, New York, N. Y., Hahnemann Medical College of Philadelphia, 1940; member AMA; died June 10, 1968, aged 54.

Webb, Roderick Cameron, Panama City; born July 29, 1914, Jackson, Tenn.; Duke University School of Medicine, 1939; member AMA; died March 25, 1968, aged 54.


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

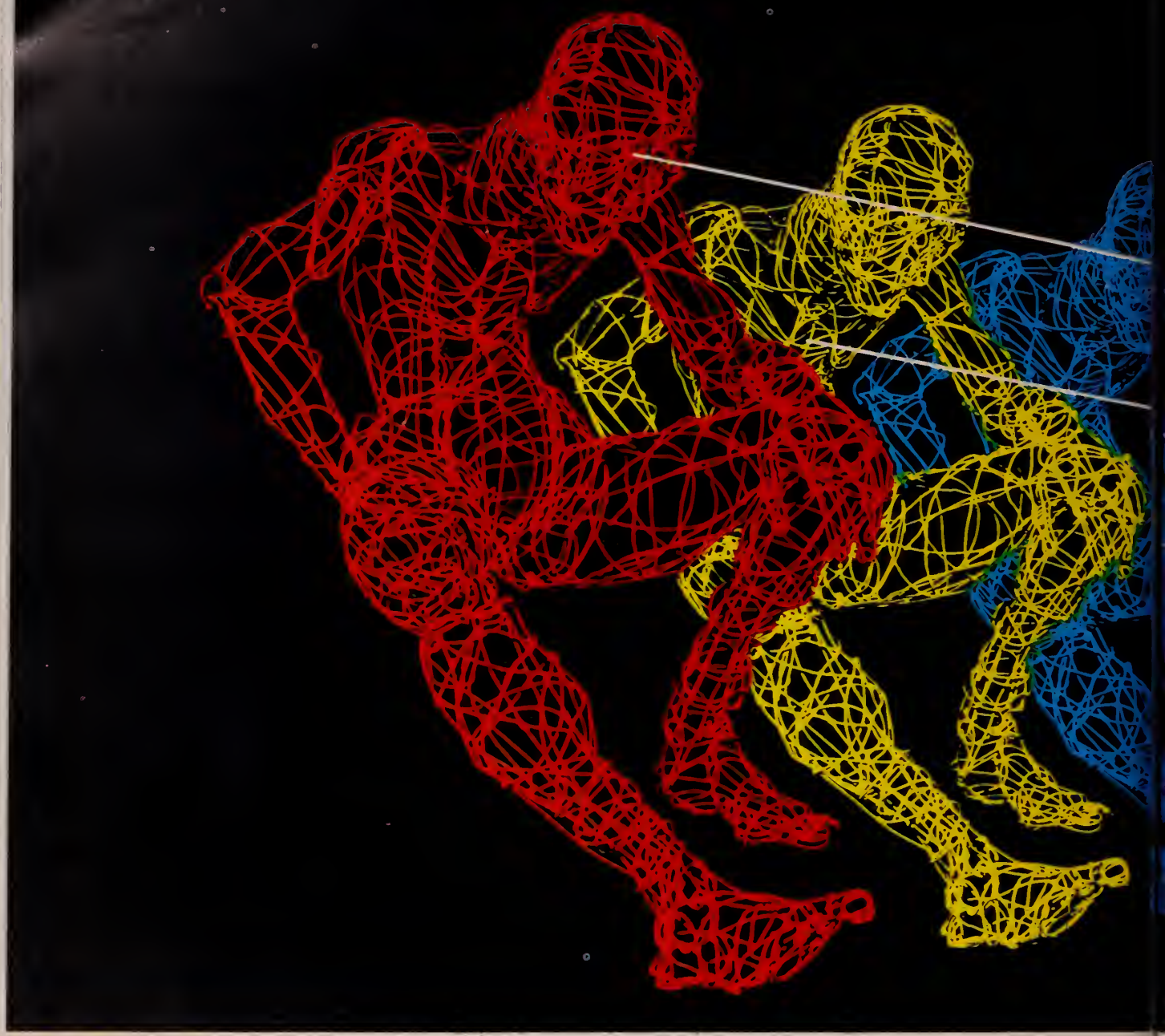
DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67



a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

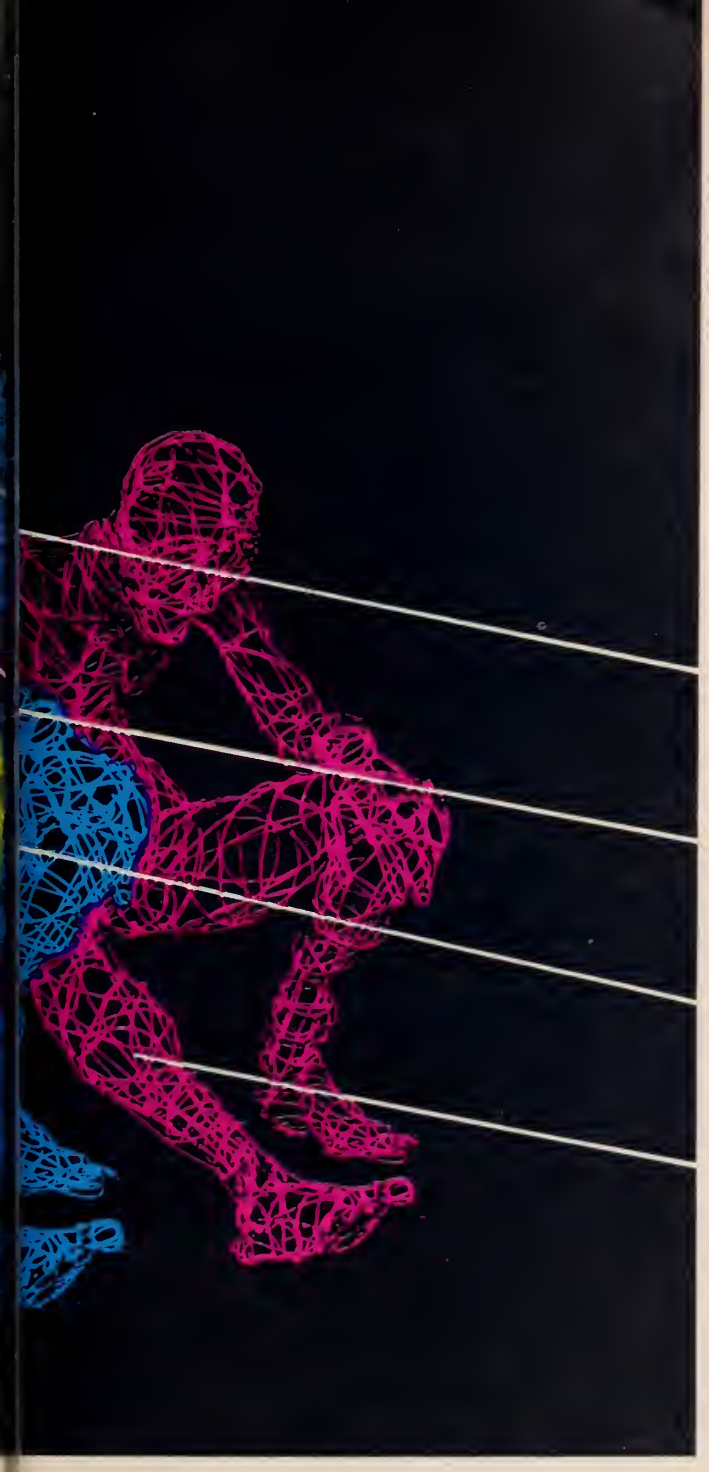
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral, or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

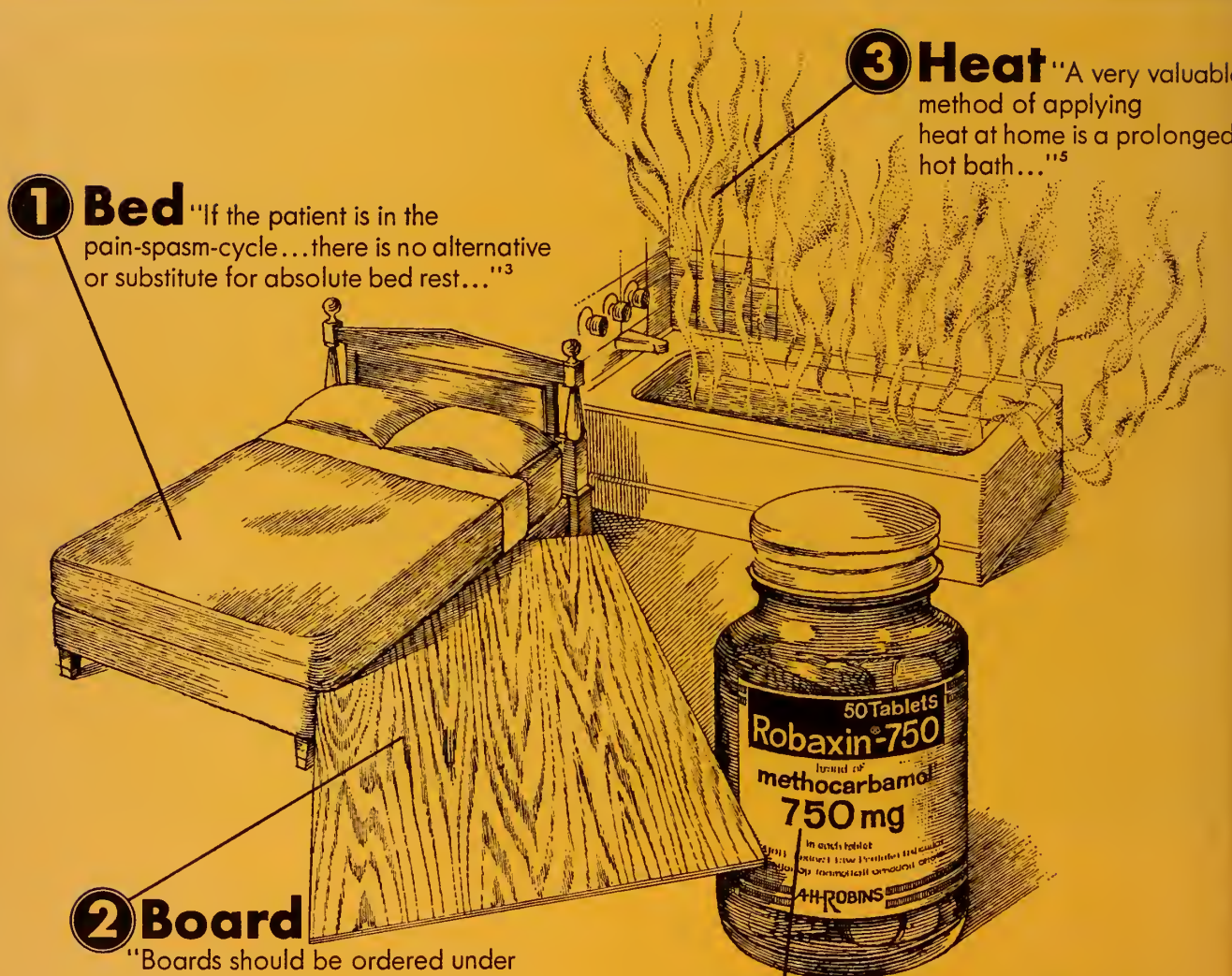
801668

Lilly

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated far relief af skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may accur rarely, but usually disappear an reduced dasage. Hypersensitivity reactians develap infrequently. See praduct literature far further details. **Also available:** Rabaxin® Tablets (methacarbamal, 500 mg.) Rabaxin Injectable (methacarbamal, 1 Gm./10 cc.)

References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

Anderson Surgical Supply Co.

Established 1916

Distributors of Known Brands of Proven Quality

TELEPHONE 229-8504
Morgan at Platt, P. O. Box 1228
TAMPA, FLORIDA 33601

TELEPHONE 376-8253
236 S.W. 4th Ave.
GAINESVILLE, FLORIDA

TELEPHONE 896-3107
556 9th St., South
ST. PETERSBURG, FLORIDA

TELEPHONE CHerry 1-9589
1818 N. Orange Ave.
ORLANDO, FLORIDA

CONVENTION PRESS

2111 North Liberty St.
Jacksonville, Florida
32206

QUALITY BOOK PRINTING

PUBLICATIONS BROCHURES

WHATEVER your first requisites may be, we always endeavor to maintain a standard of quality in keeping with our reputation for fine work — and at the same time provide the service desired. Let CONVENTION PRESS help solve your printing problems by intelligently assisting on all details.

Thomas B. Slade **Fifty-two Years in Florida** **J. Beatty Williams**

Surgical SUPPLY COMPANY

HAMILTON — RITTER — SKLAR — BURDICK
CLAY-ADAMS — B-D — BARD-PARKER — TYCOS
BAUM — WELCH-ALLYN AND MANY, MANY OTHERS

Ph. 355-8391 **P. O. Box 2580 — 1050 W. Adams Street** **Jacksonville, Fla. 32203**



P. L. DODGE MEMORIAL HOSPITAL

M. G. ISAACSON, M.D.
Medical Director
1861 N.W. South River Drive
Miami, Florida
Phone 642-3555

A nonprofit-voluntary hospital for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures including—Psychotherapy, Insulin, & Electroshock, when indicated. Adequate facilities for recreation and out-door activities. Admissions are made without regard to race, color or national origin.

Information on request

Member NAPPH, American Psychiatric Assn., & American Hospital Assn.

Index To Volume 55

January - December 1968

American Medical Association Board of Trustees (Organization) ... 967
American Medical Association Clinical Convention (Editorial) ... 1028
Anal Canal, Malignant Disease (Scientific) ... 25

Annual Meeting
- First House of Delegates ... 620
- General Session 94th Annual Meeting ... 619
- Jack Quillian Cleveland—Ninety-First President ... 571
- Ninety-Fourth Annual Meeting ... 679
- President's Address, W. Dean Steward ... 615
- Schedule of Activities Annual Meeting ... 344
- Scientific Guest Speakers ... 346
- Second House of Delegates ... 626
- The Optimistic Ninety-Fourth ... 679

Aortic Sinus of Valsalva Aneurysms, (Scientific) ... 518
Arthritis, Septic Due to Hemophilus Influenzae (Scientific) ... 723

Association News
- AMA Honors Florida Doctors ... 255
- Child Development Program Winner Announced ... 11
- Committee on Aging ... 10
- Committee on Medical Assistants ... 10
- Committee on Mental Health ... 10
- Council on Medical Services ... 10
- Tenth Annual County Medical Society Presidents and Secretaries Conference ... 254

Birth Defects Symposium
- Birth Defects Symposium Introduction ... 97
- Bladder, Extrophy ... 98
- Newborns With Facial Anomalies ... 100
- Congenital Deformities of Upper Limbs ... 102
- Granulomatosis, Septic ... 107
- Urinary Tract Abnormalities ... 110
- Meningomyelocele Treatment ... 113
- Jaw Deformities, Surgical Correction ... 116
- Wilson-Mikity Syndrome ... 121
- Birth Defects: The Practitioner's Viewpoint (Editorial) ... 125
- Birth Defects: A Continuing Challenge (Editorial) ... 126
- Birth Defects Progress (Editorial) ... 127

Bridging the Gap (Editorial) ... 338

Cancer Pain, Surgical Relief (Scientific) ... 1014
Cesarean Hysterectomy (Scientific) ... 1016
Clinical Investigation: Why Make it More Difficult (Others Are Saying) ... 242
Continuing Medical Education (Comment) ... 851
Contribution of Dr. Cason (Our Mail) ... 1029
Coronary Artery Disease, Surgical Management (Scientific) ... 17

Deaths—Members
- Baldwin, Robert S., LaBelle ... 167
- Barge, William J., Miami ... 979
- Bicknell, George F., Gainesville ... 1109
- Blackmon, William P., Eau Gallie ... 1109
- Brame, Dorothy D., Orlando ... 979
- Brown, Edgar F., Lake City ... 869
- Born, Charles A., Pensacola ... 869
- Burgner, Blanche A., Sarasota ... 869
- Campbell, Meredith F., Pompano Beach ... 979
- Campbell, W. R., Miami ... 1109
- Cason, Turner Z., Jacksonville ... 869
- Chereskin, Johnston L., Sarasota ... 167
- Christoffers, Donald M., Keystone ... 979
- Cleveland, Willard H., Rockledge ... 979
- Collins, Cecil C. Sr., Jacksonville ... 979
- Corbitt, Jack, Panama City ... 869
- Dillon, Charles F. Jr., Orlando ... 167
- Dunaway, Carl E., Miami ... 1109
- Dunham, Charles T., St. Petersburg ... 869
- Exley, David W., Miami Beach ... 167
- French, Bessie S., Miami ... 167
- Gallagher, John D., Daytona Beach ... 167
- Garrard, Hollis F., Miami ... 869
- Gilmer, Eugene S., Tampa ... 1109
- Glennan, Thomas L., Green Cove Springs ... 869
- Hall, Etheridge J., Punta Gorda ... 979
- Hart, Dean W., St. Petersburg ... 979
- Hartman, David, Allandale ... 1109
- Huntington, Frederick S., Delray Beach ... 979
- Jackson, Kenneth W., Lake Alfred ... 979
- Johnson, Marion F., Ft. Myers ... 869
- Kennedy, Alpheus T., Pensacola ... 869
- Lyell, Robert O., Miami ... 979
- Magill, John C., St. Petersburg ... 979
- Maines, John E. Jr., Gainesville ... 869
- Martin, J. William, Orlando ... 869
- Mason, John H. Jr., Miami ... 979
- McClary, George R., N. Miami ... 1109
- McGovern, William J., Ocala ... 167
- McKibben, William W., Miami ... 869
- Moore, Dean C., Marathon ... 979
- Oberlander, Irving A., Coral Gables ... 979
- Patry, Frederick L., Bradenton ... 979
- Pearson, Rufus J. Sr., Bay Pines ... 869
- Raszus, George C., North Miami Beach ... 979
- Robinson, James L. Jr., Naples ... 1109
- Ruskin, Joseph J., Tampa ... 869
- Scolaro, Joseph D., Tampa ... 979
- Skilling, Francis C., Miami ... 1109
- Simon, Herbert J., Hollywood ... 979
- Smith, Arthur B., S. Yarmouth, Mass. ... 1109
- Tocci, Frank P., Ft. Lauderdale ... 1109
- Towbin, Samuel, Miami ... 979
- Unger, Jonas, Miami Beach ... 979
- von Colditz, Grambow T., Merritt Island ... 869
- Wallace, Arthur J. Jr., Tampa ... 869
- Webb, Roderick C., Panama City ... 1109
- Wells, Samuel M., Jacksonville ... 168
- Williams, John L., Tallahassee ... 869
- Wimbish, Ralph M., St. Petersburg ... 869

Diabetes Symposium
- Diabetes Symposium Introduction ... 189
- Diabetogenic Effects of Pregnancy ... 200
- Excess Insulin in the Diabetic ... 194
- Fluid Balance Disturbances in Diabetes ... 215
- Glucagon—A Review ... 212
- Infant of the Diabetic Mother ... 205
- Insulin Biogenesis ... 190
- Juvenile Diabetes Mellitus ... 209
- One Hundred and Ten Thousand Diabetics ... 222

Diuretic, Long Term Therapy (Scientific) ... 524
Dr. John M. Packard of Pensacola (Comment) ... 1025
Double-Take (Comment) ... 852
Drug Habituation (Scientific) ... 32

Encephalitis in Florida Children (Scientific) ... 37

Feverish Recollections of 25 Years Ago (Comment) 848
Fibroelastosis, Endocardial (Editorial) 41
Fibroelastosis, Endocardial (Scientific) 28
Fifty Years Ago 62, 129, 257, 286, 478
Fingertip Injuries (Scientific) 820
Florida Individual Responsibility Program (Comment) 777
FMA Executive Director Elected to National Office (Organization) 785
FMA Science Fair Winner Captures National Honor (Organization) 785
Florida Regional Medical Program (Feature) 855
From the Editor
Belleair Florida 931
Dr. H. K. Moore 1023
Family Diplomat 564
History and Editors 773
Royal College of Physicians of London 1075
Shadowy Signs 840
Star of Hope 1075
Surgical Technic 841
The Caution Button—Not the Panic Button 563
The Eye Over Florida 840
The Library of the Royal College of Physicians of London 1075
Fluocinolone Acetonide Cream, Comparative Studies (Scientific) 1091

Gallbladder, Suprahepatic With Torsion and Gangrene (Scientific) 531
Government News
Draft Reclassification of Physicians 144
Federally Licensed Mumps Vaccine 297
Medicare and Medicaid Changes 295

Headache, Unilateral (Scientific) 513
Historical Issue—1968
Medicine in St. Augustine During the Spanish Period 731
Dr. Howell Tyson Lykes—Founder of an Empire 742
Old Doc Anna 749
A Short History of the University of Florida College of Medicine to 1960 757
Life in the Spanish Colonial Hospitals in the Late 18th Century 765
Dedication of J. Y. Porter Marker 783
Hypertension, Management With New Postganglion Blocking Agent (Scientific) 1081

Infectious Diseases (Scientific) 815

Keogh or Not to Keogh (Others Are Saying) 225

Legal Opinion: Implied Consent Law (Comment) 683
Letters to Editor 56, 160, 233, 236, 237, 376, 482, 941, 942, 1029

Medical Detective
A Lemming 153
An Affair of the Heart 488
A Multiple Etiology Death 291
The Ungrateful Spouse 60
Medical Licenses Granted 383
Medicolegal
Captain of the Ship in O. R. 957
Dating International Certificates of Vaccination 958
Law and Medicine 1076
Liability of Surgeon and Anesthesiologist 1043
New Clinical Laboratory Law 862
On Playing the Odds 958
Scared to Death 861
The Hole in the Picture 1044
Medical Student Research Issue
Student Research, University of Florida College of Medicine 411
Experimental Medicine 412
Pericardial Adhesions, Prevention of Surgically Induced 413
Doctor-Patient Communication 418
B-Streptococcal Infection in Children 427
Aqueous Humor Dynamics 431
Embryonic Chick Heart Circulation 436
Abstracts from University of Miami Medical Students 439
Student Research and the Elective Training Program 438
Effects of Nitrofurans on Fetal Erythrocytes 439
Ecology of Arthropod-Borne Virus 439
Pupillary Light Reflex During Visual Suppression 440
Anti-A and Anti-B Titers in Healthy Persons 440
Changes in Cerebral Blood Flow 440
Cerebral Microangiography 441
In Vivo Culture of Microorganisms 441
Rete Mirabile Vascular System Dissection 442
Low Temperature Tolerance, Fundus Heteroclitus 442
Uric Acid Metabolism and Cerebral Function 443
Allograft Rejection Time 443
Myocardial Ischemia 444
Tyrosinosis 444
Carbohydrate Transport in Small Intestine 445
Hypoxia Effect on Blood Pressure 445
Lasiocarpine, Changes Induced 446
Bacterial Dynamics of Burns 446
Blood Gases and AaDO2 Changes During Near-Drowning 447
Abdominal Wall Defects, Skin Grafting 447
Effective Medical Training in a Foreign Country 449
Bacteriuria in Premature Infants 452
Medicine and Religion 574
Meetings—National and Regional 71, 158, 240, 865, 973, 1024, 1108
Meetings (Postgraduate) 68, 146, 267, 486, 686, 865, 973, 1024, 1108
Mellon Mission in Haiti (Comment) 1098
Mental Health in the Public Schools (Scientific) 1085
Multiphasic Screening in Florida (Scientific) 1012
Myocardial Infarction, Indications for Cardiac Pacing (Scientific) 1079

Narcotic Addiction (Scientific) 831
New Editor (Comment) 573
Nurse-Physician Teamwork (Editorial) 839
Nursing—Too Vital to be Taken For Granted (Comment) 551
Notes From Vietnam (Comment) 850

Ophthalmology Symposium
Toward Increased Understanding 897
Dyslexia and the Private Practitioner 898
Dyslexia and the Research Ophthalmologist 903
Dyslexia and the Neuro-Ophthalmologist 906
Eye Care and General Medicine 910
Ocular Problems of the Elderly 912
Diabetes: Diagnosis by Retinoscope 915
The Eye and Whiplash Injuries 917
Recent Advances in Cataract Surgery 919
Contact Lenses: Their Place in Medicine Today 923
Responsibility of Pediatrician and Family Physician for Prevention of Blindness in the Preschool Child 926

Pact or Placque (poem) 778
Papilledema, Relationship to Chronic Subdural Hematoma (Scientific) 1094
Photosensitivity, Drug Induced (Scientific) 607
Physician Participation in Good Government (Comment) 1027
Pleural Drainage for Ambulatory Patient (Scientific) 835
Pneumonia—Work of the Winter (Scientific) 1003
President's Page
AMA Annual Meeting 713
A Needless Waste 185
Advance Unto Regression? 7
Aesculapius vs. Hermes 89
Florida Regional Medical Program 885
Ingredients for Healing 1069
Responsibilities 399
See You in Hollywood Beach 279
The AMA and You 993
The Art of Medicine 511
Thoughts on the 1968 Annual Meeting 597
Workmen's Compensation Medical Fees 807
Psychiatric Patients Self-Evaluation (Scientific) 1010
Public Health Topics
Hearing Loss in the Aging 246
Home Health Care in Florida 65
Is It a Virus? 138

Reminiscences (Comment) 1026
Renaissance in Jacksonville (Comment) 839
Republican and Democratic National Conventions (Feature) 963
Research, Clinical—Failure and Frustration (Scientific) 1088

Salute to the Medical Politician (Others Are Saying) 148
Second Annual Benefit Art Show (Comment) 685
Small Bowel Ulceration (Scientific) 532
Snakebite Symposium
Definitive Study of Snakebite 330
Diagnosis, Symptoms, Treatment and Sequelae of Envenomation by Crotalus Adamanteus and Genus Ancistrodon 327
Mojave Rattlesnake, Treatment of Bite 324
Snakebite Myths and Misinformation 319
Venomous Snakebite, Emergency Room Treatment 317
Venomous Snakebite in Florida 308
Seven Years in Retrospect (Editorial) 455
Shigellosis (Scientific) 540
Special Articles
Coral Killer Control 364
Florida State Board of Medical Examiners 45
Florida's Present Mental Health Problem 49
New Medical Specialty—Legislative Medicine 463
Nursing in Florida 457
Project Teenage Alert 357
The Poison Ivy League 360
State Science Awards 577
Subclavian Steal Syndrome (Scientific) 1005

The Admiral's Physicians (Feature) 949
The Nurse and Physician Associates in Patient Care and Communication (Comment) 937
The Physician's Place in Public Affairs (Feature) 687
Tribute to Dr. Thad Moseley 573
Trigger Thumb in Infants and Children (Scientific) 819
Tuberculosis, Chemoprophylaxis for Prevention (Others Are Saying) 372
Tuberculosis, Chemoprophylaxis (Editorial) 340
University of Miami Medical School's First Graduating Class (Comment) 555
Uremic Syndrome Treatment (Scientific) 535

Well Done, Thad 572
Wilbur Cohen (Comment) 943

AUTHORS

Anderson, William H. Jr., Ocala 910
Andrews, Carl E., West Palm Beach 308
Angella, Joseph J., Miami 121
Applerouth, Daniel, Miami 439
Arey, Donald L. Jr., Orlando 1005
Arias, Doralys, Miami 121
Auld, Albert W., Coral Gables 1094

Bakst, Stewart Roy, Miami 439
Barnard, George W., Gainesville 831
Barrett-Connor, Elizabeth, Miami 540
Barrow, Mark V., Gainesville 757
Bartley, Thomas D., Gainesville 851
Bates, T. H., Lake City 1029
Beehler, Cecil C., Ft. Myers 912
Becker, Melvin L., Miami 116
Belle, Martin S., Miami 524, 1081
Benton, Curtis D. Jr., Ft. Lauderdale 898
Berkowitz, Samuel, Miami 100
Bond, James O., Tampa 37
Brenner, R. L., Miami 440
Buff, Elsie E., Jacksonville 138
Burke, Herbert A. Jr., Jacksonville 190
Butler, Fred A., Naples 848

Carter, Charles H., Orlando 127
Charles, Steven, Miami 440
Chesney, John G., Miami 17
Clarkson, John G., Miami 446
Cluff, Leighton E., Gainesville 815
Cohen, Fred L., Miami 449
Collins, Clyde M., Jacksonville 839
Connor, James D., Miami 107, 540
Conners, James J., Jacksonville 819
Cooke, Francis N., Miami 1009, 1028

Daughtry, De Witt C., Miami 17
Davidson, Eugene T., Lakeland 209
Davis, Charles M., Miami 607
Dean, Goble D., Miami 1077
Dees, John E., Miami 308
Denham, Sam W., Jacksonville 1018
Denman, Sidney B., Gainesville 1010
Dever, Richard C., Miami 531
DeVito, James J., St. Augustine 379, 850
Dooley, Donald M., Coral Gables 1094

Edwards, Ray O., Jacksonville 308
Edwards, Thomas S., Jacksonville 919
Ehrenkranz, N. Joel, Miami 1003

Fabric, Robert K., Miami 835
Fairman, David, Coral Gables 1014
Farrington, Joseph, Jacksonville 1093
Fernandez, Pedro, Miami Beach 518
Flatt, Richard S., Sarasota 1091
Fleming, Jack W., Pensacola 1025
Fleming, Richard M., Miami Beach 679
Fogel, Bernard J., Miami 97, 98, 107, 121, 438
Ford, Malcolm J., Jacksonville 65

Frydman, Joseph E., Jacksonville 1012
Fulghum, James E., Jacksonville 222, 246, 1012

Galluccio, Anthony C., Hollywood 340, 778
Gates, Emily H., Jacksonville 37
Gehres, George W., Jacksonville 308, 319
Gennaro, Joseph F. Jr., Louisville, Ky. 308, 324 327
Gentsch, Thomas O., Miami 17
Gessner, Ira H., Gainesville 205
Giammons, Samuel, Miami 41
Gibson, William J., St. Augustine 917
Gilmore, Hugh R., Miami 1081
Glaser, Joel S., Jacksonville 1012
Godbey, Asa L., Gainesville 1088
Gray, Harry T., Jacksonville 683, 1043
Greenberg, Jack J., Miami Beach 518
Greenberg, Samuel I., Miami 1085
Greenfield, Maurice M., Miami 148
Guedes, Beny L., Jacksonville 436
Guyon, Barbara, Gainesville 1010

Halpert, Edward S., Gainesville 431
Hampton, H. Phillip, Tampa 855, 885
Hankins, Gary C., Gainesville 418
Hasty, Frederick E., Coral Gables 923
Hege, Mrs. John R. Jr., Hollywood 685
Hendra, Richard I., Detroit, Mich. 1088
Hourihan, Alice, Miami 551
Howie, Donald L., St. Petersburg 60, 153, 291, 488, 861, 958, 1044
Hulet, William H., Miami 535
Hurt, Floyd K., Jacksonville 679

Ingram, James M., Tampa 742

Jackson, Kenneth W., Lake Alfred 308
Jacoby, John E., Miami 440
Jannach, Joseph R., Miami 452
Jordan, Maliva, Miami 98
Judd, Walter H., Washington, D. C. 687

Kaplan, R. S., Miami 440
Katims, Robert B., Miami 212
Kenyon, Norman M., Coral Gables 515
Keyes, Macey H., Miami 524, 1081
Kirkpatrick, H. L. Jr., Miami 440
Krovetz, L. Jerome, Gainesville 28

Lamphier, Timothy A., Miami 532
LaPlatney, Donald R., Miami 1016
Larsen, Parry B., Miami 17
Lattimore, Nancy E., Gainesville 427
Lehman, David J., Hollywood 367
Lewis, Arthur L., Tampa 37
Lorincz, Andrew E., Gainesville 126
Lozito, John C., Miami 441
Lundblad, Edward G., Miami 441

Magnuson, Warren G., Washington, D. C. 1102
Martin, Samuel P., Gainesville 855
Marvan, Robert D., Miami 442
McAndrew, John J., Orlando 360, 376
McCleave, Paul B., Chicago 574
McCollough, Newton C., Orlando 317, 327
McCreary, Robert H., Miami 442
McLoughlin, Thomas G., Gainesville 28
Meyers, Francis R., Punta Gorda 1012
Miller, Emery C., Winston-Salem, N. C. 200
Modell, Jerome, Miami 447
Montgomery, Burtis E., Chicago 967
Moore, C. W., Miami 442
Morris, James, Jacksonville 25
Morrow, Matthew E. Jr., Jacksonville 189
Moseley, Thad, Jacksonville 25, 307, 308, 455, 573, 897

Needles, Robert J., St. Petersburg 1026
Nixon, Eugene L., Jacksonville 939, 1101
Nyhan, William L., Miami 41, 723

Obi, Lewis J., Jacksonville 819
O'Leary, James A., Miami 1016

Palmer, George S., Tallahassee 45
Parnes, Edmund I., Miami 116
Pearson, Howard A., Gainesville 412
Perlmutter, Irwin, Coral Gables 1014, 1094
Pesek, Joseph, Miami 443
Poole, Catherine A., Miami 98, 110, 723
Prather, E. Charlton, Orange Park 138
Pullen, Fredric W. II., Miami 513

Ramirez, Jose, Miami 452
Ramsey, Frank B., Indianapolis 573
Reilly, Carl N., Punta Gorda 777
Reynolds, David H., Miami 113
Rhoten, William B., Louisville, Ky. 324
Ritch, Linda, Gainesville 831
Rooks, James, Miami 444
Rubin, Melvin L., Gainesville 903
Rubin, Nathan S., Pensacola 915
Ruffin, William C. Jr., Gainesville 1010

Sackett, Walter W. Jr., Miami 463, 943
Samara, Betty J., Miami 535
Samet, Philip, Miami Beach 518, 1079
Sanford, Howard, Miami 1081
Schiebler, Gerold L., Gainesville 28
Schmitt, George F., Miami 215
Schmidt, Richard P., Gainesville 516
Schneider, Nathan J., Jacksonville 862
Schneider, Neil S., Miami 443
Sheppard, Ben J., Coral Gables 957
Shipp, Joseph C., Gainesville 194
Shocket Everett, Miami Beach 1098
Skinner, Richard G. Jr., Jacksonville 125
Smith, Ballard F. Jr., Miami 444
Smith, Dorothy M., Gainesville 457
Smith, Edwin F., Atlanta,, Georgia 852
Smith, J. Lawton, Miami 906
Smith, Leonard O. Jr., Gainesville 413
Snow, John W., Jacksonville 820
Snyder, Clifford C., Salt Lake City, Utah 308, 330
Snyder, Gilbert B., Miami 102
Sowder, Wilson T., Jacksonville 319
Spear, Harold C., Miami 17
Staton, Younger A., West Palm Beach 926
Straight, William M., Miami 56, 731, 765, 783, 949
Sugerman, David L., Miami 535
Suter, Emanuel, Gainesville 411

Tate, Charles F. Jr., Miami 1102
Tingle, David, Vero Beach 32
Thomas, David, Miami 444
Trumbill, Horace R., Miami 445
Tsai, Enoch N. C., Miami 445

Ungaro, Peter, Miami 443

Viera, Cristobal Jr., Miami 444
Visintine, Aarolyn M., Miami 723

Wachtel, Leo M., Jacksonville 572
Walker, James W., Jacksonville 457
Wand, Joseph S., Miami 446
Ward, C. Gillon, Miami 446
Warren, W. Dean, Miami 438
Warson, Samuel R., Sarasota 937
Welch, William B., Miami 963, 1027
Wharton, Dwight J., Jacksonville 340
Williams, H. D., Miami 447
Williams, Moke W., Ft. Lauderdale 49
Witten, Victor H., Miami 607, 852
Woldow, Norman, Miami 442

Zies, Leonar, Miami 452
Zies, Peter, Miami 447

Florida Medical classified

physicians wanted

General Practitioners

EXCELLENT OPPORTUNITY for general practitioner in community of 15,000; central Florida; 76 bed JCAH hospital. Write or call collect R. C. Thompson, Bartow Memorial Hospital, Bartow, Fla.

WANTED: Physician to do general practice with two established GP's for association and eventual partnership. 35-bed approved JCAH hospital soon to expand—with modern professional arts bldg. and northeast coast Florida. Write C-843, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Hospital based physicians to do general practice. Central Florida, 60 bed, JCAH hospital, will provide office space, equipment, personnel, etc. "Financial floor" (basic salary) open to negotiation. Contact W. Harold O'Neal, Administrator, Highlands General Hospital, 3600 South Highlands Avenue, Sebring, Florida 33870. EV 5-6101.

URGENTLY NEEDED.—GP to join well established physician. Newly constructed office including laboratory and x-ray. Town close to Miami and Palm Beaches with all sports available. Phone 983-8531, Clewiston, Fla.

WANTED: General practitioner for association with mixed group. Salary plus percentage and all expenses. Share coverage on day off, weekends, vacations. Guarantee $20,000 first year. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305) 636-4221.

URGENTLY NEEDED: GP to assist established but presently incapacitated physician in operation of 35-bed county hospital. Association or partnership if desired. Compensation open. North central Florida. Write C-850, P.O. Box 2411, Jacksonville, Fla. 32203.

Classified advertising rates are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

Specialists

WANTED: Internist for association with mixed group. Salary plus percentage and all expenses. Share coverage on days off, weekends, vacations. Compensation open. Contact T. C. Kenaston Jr., M.D., Box 550, Cocoa, Fla. 32922. Phone (305)636-4221.

INTERNIST WANTED: To join two-man "professional association" in greater Miami area. Salary open, tax-free pension or profit-sharing available. Share time off. Write C-789, P.O. Box 2411, Jacksonville, Fla. 32203.

PSYCHIATRIST WANTED-NEEDED: To continue county solo nine year practice terminated by sudden death. Office, furniture, files, patients ready, waiting. Local hospital psychiatric facility under construction. Contact Mrs. Frederick L. Patry, 5912 Riverview Blvd. W., Bradenton, Fla. 33505.

WANTED: Internal medicine practice opportunity for board eligible internist with subspecialty interest in Southeastern coastal community. Starting salary $21,000 first year with opportunity for full partnership. Write C-844, P.O. Box 2411, Jacksonville, Fla. 32203.

SURGEON WANTED: To enter established practice as only surgeon in North Florida college town. Excellent central location near two interstate highways; excellent hunting, fishing and golf. Write C-829, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST WANTED: Board eligible or certified. Cardiology interest. In suburban Miami, Florida. Long established professional association to replace third man vacancy. Immediate opportunity. Salary negotiable. Corporation participation available after first year. Send curriculum vitae, age, marital and military status, licensure and financial interest to C-860, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Internist, ENT man and pediatrician for association with established multispecialty group. Contact: W. T. Christian, Clinic Manager, White-Wilson Clinic, P. O. Drawer M-M, Ft. Walton Beach, Fla. 32548.

INTERNIST WANTED: Board qualified or certified to join two other internists in private practice in Miami Beach. Write C-811, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Partnership-internist to head department of large established Lauderdale practice. Excellent facilities, new building with unusual ancillary services. Write C-848, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Winter Haven, Polk County, central Florida, home of Cypress Gardens. ENT man sought to join four physicians, two dentists, lab technician and pharmacist who have built new medical complex. Option to buy into corporate structure after probationary period. Professional and economic independence. Write C-840, P.O. Box 2411, Jacksonville, Fla. 32203.

Miscellaneous

EMERGENCY ROOM PHYSICIANS for southeast Florida hospital. Must have Florida license. $22,000 minimum. Positions available immediately. Write C-854, P.O. Box 2411, Jacksonville, Fla. 32203.

G. P. OR INTERNIST for immediate association in an active practice. Financial and other details open for agreement. Call collect, R. H. Shedd, M.D. (813) 639-1640.

WANTED: Physicians to practice full time emergency medicine. Advantages we have to offer at present time: (1) Regular hours (2) Reasonable remuneration (3) Excellent growth potential. If interested, send confidential reply to C-857, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST OR GP: North Miami Beach, Fla. $18,000 start—leads to association. Contact Mr. Harold Kwart, 9999 N.E. 2nd Ave., Miami Shores, Fla. 33138.

GP OR INTERNIST to associate with three-man group, one surgeon and two GP's. Suburban Jacksonville. 30,000 first year to approximately $40,000 in two years of partnership as agreed. Call Dr. M. B. Bergh, (904) 264-9511.

WANTED: GP or general surgeon to join GP in small but growing community near medical school. Two new offices available with new hospital fully equipped. Write C-834, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: G.P. or internist for private practice netting at least $25,000 yearly. Pleasant surroundings, Jacksonville area. Seventy-five bed county hospital adjacent to modern office building with two colleagues. Write C-842, P.O. Box 2411, Jacksonville, Fla. 32203.

WANTED: Florida licensed physician, experienced in all phases of general medicine, especially surgery, for association with board general surgeon-gynecologist. Excellent salary with partnership after two years. Write C-856, P.O. Box 2411, Jacksonville, Fla. 32203.

EMERGENCY ROOM PHYSICIAN: Position open in rapidly expanding 600 bed, fully accredited general hospital with approved internship-residency program. On beautiful east coast of Florida; serving a county of 200,000; situated at world's most famous beach; near Daytona International Speedway; year-round recreation and sports; fishing, boating, and hunting; ideal climate for family living.

Salary negotiable $20,000 to $30,000, liberal pension program, Social Security benefits, family hospitalization insurance, paid vacation, 40 hour week. Florida license necessary. All replies confidential. Write or call E. K. Prentice, Administrator, Halifax District Hospital, Daytona Beach, Florida 32015; telephone: 904-255-4411.

WANTED: Emergency room physician in hospital; to join group of private physicians, 42 hour week, income $20,000 plus. Contact Bruce S. Webster, M.D., 1416 South Orange Ave., Orlando, Fla. 32806. Phone 647-5728.

situations wanted

POSITION WANTED: Indiana University (AOA) radiology resident, age 30, military service completed, seeks radiology group position for July 1969. Have Florida license. Write C-846, P.O. Box 2411, Jacksonville, Fla. 32203.

INTERNIST-CARDIOLOGIST. Board eligible, university trained, seeks clinical association with internist, group or hospital with opportunity for catheterization and/or coronary care unit work. Available August 1969. Write C-852, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL SURGEON: Board certified, licensed in Florida 1968. Desires association with another surgeon or group in a coastal city of central or southern Florida. Write C-855, P.O. Box 2411, Jacksonville, Fla. 32203.

POSITION WANTED: Ob-Gyn. Board eligible, university trained, desires partnership. Available for practice August 1969 following completion of military obligation. Write C-861, P.O. Box 2411, Jacksonville, Fla. 32203.

practices for sale

PRACTICE AVAILABLE: Pediatrician in suburban Washington, D.C. would like to exchange busy practice with pediatrician having comparable practice in Florida. Give particulars in letter. Write C-862, P.O. Box 2411, Jacksonville, Fla. 32203.

GENERAL PRACTICE in Cape Kennedy area; established 5 years; grossing $70,000; excellent opportunity; potential $100,000. No cash necessary; all supplies and equipment. Will introduce; agreeable terms. Write C-859, P.O. Box 2411, Jacksonville, Fla. 32203.

real estate

FOR SALE OR LEASE: Office, residence and parking area opposite Mound Park and All Children's Hospital. Retiring from practice of radiology. Phone 862-6962, St. Petersburg, Fla.

MEDICAL OFFICE FOR RENT: Pensacola, Florida. New office across from Baptist hospital. 1,000 sq. ft. Carpeted throughout. Completely modern. Furnished or unfurnished. Available Jan. 1. Write C-851, P.O. Box 2411, Jacksonville, Fla. 32203.

FOR RENT: One office left in beautiful new medical office complex across the street from community hospital expanding to 175 beds in near future. 1,200 sq. ft., 3 examining rooms, laboratory and private office, or can build to suit. Unique option to purchase shares in corporation. Excellent opportunity for generalist or specialist all fields. Medical Gardens of Venice, Inc., 209 Palermo Place, Venice, Florida 33595. Phone (305) 488-7716.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

Florida Medical Association Officers and Council Chairmen

Officers

Jack Q. Cleveland, M.D., Coral Gables, President
Henry J. Babers Jr., M.D., Gainesville, President-Elect
Irving E. Hall Jr., M.D., Bradenton, Vice President
James T. Cook, M.D., Marianna, Speaker of the House
Charles K. Donegan, M.D., St. Petersburg, Vice Speaker
Floyd K. Hurt, M.D., Jacksonville, Secretary-Treasurer
W. Dean Steward, M.D., Orlando, Immediate Past President
W. Harold Parham, Jacksonville, Executive Director

Chairmen

James W. Walker, M.D., Jacksonville, Allied Professions and Vocations
John J. Cheleden, M.D., Daytona Beach, Judicial
Jere W. Annis, M.D., Lakeland, Legislation and Public Agencies
Jack A. MaCris, M.D., St. Petersburg, Medical Economics
James M. Ingram, M.D., Tampa, Medical Services
Richard C. Dever, M.D., Miami, Scientific Activities
William C. Roberts, M.D., Panama City, Special Activities
Joseph G. Matthews, M.D., Orlando, Specialty Medicine
Hawley H. Seiler, M.D., Tampa, Voluntary Health Agencies

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital for diagnosis and treatment of psychiatric and neurological disorders. Hospital and out-patient services.

James Asa Shield, M.D.
George S. Fultz, Jr., M.D.
Catherine T. Ray, M.D.

Weir M. Tucker, M.D.
Edward W. Gamble, III, M.D.
Gerald W. Atkinson, M.D.



when relief
means so much
in keeping
your G.U.
patient comfortable

URISED®

CONAL

Clinically effective for G.U. Therapy[1-5]

There are not many drug combinations in use today which can claim to have served the medical profession for more than 50 years. Such a record reflects the continued confidence of physicians in URISED. This is not a dramatic "wonder drug"—but a *useful* one.

It fills a need in urologic and general practice—a need for a mild but reliable agent with a very low order of toxicity. It can be used alone to treat mild and uncomplicated urinary infections. It can be used as "interim therapy" while awaiting the results of urine culture. It can be used as an adjunct (to relieve pain and spasm) with almost any other form of antibacterial therapy.

The characteristic blue/green urine tells the patient that something is happening. The patient generally tells *you* that symptomatic relief follows the first dose.

REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

URISED®

Each Blue-Coated Tablet contains Active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

PRECAUTIONS: Administer with caution to persons with atropine idiosyncrasy or cardiac disease.

SIDE EFFECTS: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

(*Stocked Nationally Through All Service Wholesale Druggists*)



CONAL
PHARMACEUTICALS INC
CHICAGO ILLINOIS 60640

MANUFACTURERS OF URICEUTICAL® SPECIALTIES

ANESTACON™ • CYSTOSPAZ® • MANDACON™ • URISED®
URISEDAMINE® • ŪTRASUL® Tablets and Suspension

Printed in U.S.A.

MAR. 1968

Florida Medical advertisers

Anderson Surgical Supply Co. 1119

Breon Laboratories
Fergon 1109

Bristol Laboratories
Tetrex F 1070

Burroughs-Wellcome Co.
Empirin 1070a

Coca Cola Co. 1112

Conal Pharmaceuticals, Inc.
Urised 1126a

Convention Press 1119

Eaton Laboratories
Furacin 1062

Geigy Pharmaceuticals
Butazolidin 1070a
Tandearil 1116-1118

Highland Hospital, Inc. 1112

Hill Crest Hospital 1114

Hynson, Westcott & Dunning, Inc.
Bromsulphalein 1063

Lakeland Manor 1113

Lakeside Laboratories
Norpramin 1104-1105

Lederle Laboratories
Achrocidin 1070a
Declomycin 1065
Histoplasmin Tine Test 1113
Peritinic 1110a

Eli Lilly & Co.
Trinsicon 1118a
V-Cillin K 1078

Loma Linda
Soyaloc 1060

Medical Supply Co. 1113

Merck, Sharp & Dohme
Hydropres 1072-1074

New Orleans Graduate
Medical Assembly 1109

Parke-Davis & Co.
Dilantin 1118a
Povan 1096-1097

Pitman-Moore
Novahistine 1094a-1095

P. L. Dodge Memorial Hospital 1119

PM of Florida 1114

William P. Poythress & Co.
Trocinate 1103

Riker Laboratories
Norflex 1066

A. H. Robins, Inc.
Robaxin 1118a
Robinul Forte 1106-1107
Robitussin 1114

Roche Laboratories
Valium ..... Back Cover
NCME-TV 1071

J. B. Roerig & Co.
Tao 1110a

Sandoz
Mellaril 1110a

G. D. Searle Co.
Ovulen-21 ..... 1094a

Smith, Kline & French
Ornade 1110

Strasenburgh Laboratories
Omni-Tuss 1110a

Stuart Co.
Mylanta 1094a

Surgical Supply Co. 1119

Tucker Hospital, Inc. 1126

NY ACADEMY MED LIBRARY
2 EAST 103RD ST
1 NEW YORK NY 10029
OF MEDICINE



ready for bed..

but not for sleep

...because psychic tension may not stop at night

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®
(diazepam)

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
NOV 7 [illegible]	Lutkin